GOVERNMENT PROGRAMS ON ALCOHOLISM

A REVIEW OF ACTIVITIES IN SOME FOREIGN COUNTRIES

by E. M. JELLINEK, M.Ed., Sc.D.

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INTRODUCTION

From broad travel and wide experience this world-known specialist contributes this document which we hope will be of use to workers in this field and others concerned with addiction problems.

Dr. Jellinek's international review of government programs has a companion piece: "Survey of Organizations in the Field of Alcoholism, Canada, 1960" which appeared in Laval Medical (Oct. '62) and in the Canadian Medical Association Journal (May 11 '63). The latter reports on treatment, training, research and other aspects of the Canadian scene, while this Memorandum comments on these and many other features of the international picture.

Each of these studies arose from considerations of this Department's Subcommittee on Alcoholism and Other Drugs -- a Subcommittee of the Advisory Committee on Mental Health. The Subcommittee was concerned about the relatively limited amount of technical and professional material on alcoholism appearing in the regular journals. It noted, too, that some professional training centres had no undergraduate lectures on alcoholism, and that graduate training across Canada was quite spotty. The need for more authoritative information was obvious, especially as a national organization -- The Canadian Council on Alcoholism -- was being formed.

We were most fortunate in securing the services of such an international authority to contribute this world-wide review of government programs on alcoholism. Dr. Jellinek is currently a Visiting Professor of Psychiatry at Stanford University and Research Associate with the Institute for the Study of Human Problems, Stanford, California. He is also Editor of the Encyclopedia of Alcohol Problems.

During preparation of the manuscript, Dr. Jellinek was associated with the Alcoholism and Drug Addiction Foundation of Ontario and we wish to express our appreciation to the Foundation for its assistance in the preparation of this Memorandum.

Morgan Martin, M.D., M.Sc.,
Chief, Mental Health Division,
Department of National Health and Welfare.

April, 1963

FOREWORD

This review of alcoholism programs in selected countries is largely limited to procedures currently in force. Some of the old legislation on the care of alcoholics and controls of production and sales are mentioned whenever the changes are of particular interest.

With the exception of Russia, Czechoslovakia and Poland, the writer has visited all of the countries mentioned in this review. Much of the presentation is based on oral and written information received from experts in those countries. This information was supplemented by lectures given at the Seventh and Eighth Summer Institute of Scientific Studies for the Prevention and Treatment of Alcoholism, Paris, 1960, and Amsterdam, 1961, respectively. These lectures were supplied to me in mimeographed form.

It may be pointed out that there are very few articles published in journals on the matter of government programs, either in their totality or in some of their specific aspects. However, information may be obtained from agency annual reports and journals of a house organ nature with very limited circulation.

Opinions expressed in this monograph are, of course, my own and do not necessarily reflect those of the Department of National Health and Welfare or its Mental Health Division.

E. M. J.

GOVERNMENT PROGRAMS ON ALCOHOLISM

A REVIEW OF THE ACTIVITIES IN SOME FOREIGN COUNTRIES

I. SKETCH OF THE ELEMENTS OF TOTAL PROGRAMS

Among the concerns of government with the health and social welfare of the people are problems arising from the excessive use of alcoholic beverages. These problems are not limited to the extreme form of excess commonly referred to as "alcoholism", but embrace a large variety of what might be called sub-alcoholic problems.

The interest of government in these problems is heightened through the interference of the abuse of alcohol with many public health campaigns (e.g. tuberculosis, nutritional programs, maternal and child health).

First a brief sketch of the elements of a total government program on alcoholism and other drinking problems is presented as they emerge from an international review. This sketch is followed by a more detailed discussion of the main points and of the ways and means which have been implemented or proposed in various countries. The main body of the review consists, however, of the description of - and comments upon - the activities relating to alcoholism and other drinking problems in a number of selected countries which have interesting experiences in this field.

On the North American continent we are accustomed to think of alcoholism programs in terms of the activities of provincial agency or state agency on alcoholism. But even when a broad legislative mandate specifies treatment, research and education as the objectives of such an agency, the activities of these bodies do not and should not cover all those activities, which government must undertake in order to cope with all of the problems which arise from alcoholism and other excessive use of alcoholic beverages. We must get accustomed to think in terms of total government programs on alcohol and alcoholism. Frequently government itself does not realize that it has a total program on these matters, particularly since the various necessary activities do not arise from a central idea, but from activities which are adventitious and do not seem to be inter-related. In some European countries, a central idea and an attempt at co-ordination does exist, but this does not necessarily imply that the execution of the total program is admirable and should be emulated. But the experiences of various countries are at least instructive in either a positive or negative sense.

The action which governments undertake in relation to these problems may be expressed here in terms of prevention:

(1) the prevention of the progression of existing alcoholism and other drinking problems.

(2) the prevention of new growth of alcoholism and other drinking problems.

These two areas of prevention have many implications and involvements which must be analyzed in order to arrive at a "total governmental alcoholism program".

A number of facilities for the needs of the alcoholic and sub-alcoholic population are involved. Some of these facilities are strictly governmental, some may be semi-private or entirely privately operated. Thus there arises the question of co-ordination in order to assure the greatest efficacy of all existing and potential facilities, and the question of which department or agency should carry out the co-ordination. Such an agency may be an existing government department, or a central body specially created for that purpose.

Prevention of the Progression of Existing Alcoholism and Other Drinking Problems

The attack on the problems given in the above heading is necessarily of a therapeutic and a re-educational nature and, of course, requires facilities for therapy.

Since the alcoholic population is not homogeneous, either socially economically, physically or psychologically, a variety of facilities may be required. It does not seem necessary here to go into a classification of alcoholics and individuals with alcohol problems, but it will suffice to enumerate some attributes which determine certain needs. Among the population with frank alcoholism and other drinking problems there are:

(a) Persons who in spite of their drinking handicaps, are gainfully employed and are free of gross physical and/or mental complications. The treatment of these people may be carried out advantageously in out-patient clinics.

(b) Persons as described under item (a) except that they have temporary physical complications, such as severe acute intoxication or diseases of chronic alcoholism. Such persons may require short-term hospitalization (and after termination of hospital care, should be referred to an out-patient clinic and some such body as Alcoholics Anonymous or its equivalents in various countries).

One could think in this connection of a governmental In-Patient Unit for alcoholics with acute intoxication, but such a unit would be justified only as a small unit for training and research purposes rather than as a modus for covering the needs of this particular segment of the alcoholic population. The main burden would fall upon hospitals. (See, however, the example of A.A. nursing homes in Norway page 37.)

Such procedure requires the willingness of hospitals to admit such patients, and they should not stop at the treatment of the acute condition but channel the patients (through intelligent referral) into treatment of his alcoholic comportment. For this purpose hospital staff with some training in the field of alcoholism, or a consultation service of specialized physicians are required. Training and consulation would devolve largely upon government sponsored clinics and hospitals.

(c) Homeless persons with alcoholism or other drinking problems who are not handicapped by gross physical and/or mental complications need a place where they can live while they are being treated at the Out-Patient Clinic and for a certain period after they are discharged from such treatment and while they are seeking employment. This need can be covered by the so-called Half-Way Houses, some of which may be government agencies and others may be owned and operated by philanthropic or denominational bodies, if possible, in consulation with a government supported clinic or hospital for alcoholics.

(d) The same applies to the small number of persons seeking treatment at a government out-patient clinic who live too far away for regular commuting.

(e) Alcoholics with psychosis, and these, of course, need admission to mental hospitals.

(f) Alcoholics or persons with drinking problems who are under sentence for misdemeanors. In these instances, there is need for a specialized penal institution or preferably a probationary institution.

The preference for a Probationary Institution is expressed here because in the framework of a Penal Institution, with its penalogically oriented staff a proper therapeutic attitude cannot be expected. On the other hand, persons with marked disciplinary problems and psychopathic criminal alcoholics are not suitable for admission to an institution of probationary character, and may be placed in highly specialized penal institutions with adequate medico-psychiatric staffs. (See Denmark page 42.)

(g) Alcoholics with serious physical handicaps. These need rehabilitation in the strict sense of the word, and must be referred to the proper rehabilitation agencies. Some systematic consultation on the part of government sponsored clinics may be required in those instances. The incidence of such handicaps among alcoholics is rather small.

(h) In some instances vocational guidance may be indicated, and this requires co-operation between the facilities for treating alcoholics on the one side and the vocational guidance agencies on the other side.

(i) Driving "under the influence" is in many instances a sub-alcoholic problem which requires special police measures which may include "Drivers' Clinics".

Co-operation and consultation are also indicated among treatment centres, and among child guidance agencies (alcohol problems of parents), welfare agencies, family social work agencies, law enforcement agencies, etc. Consultation in these matters devolves upon government sponsored clinics and hospitals for alcoholics.

In order to prevent the progression of existing alcoholism and other drinking problems, educational and consultative activities are required. In order to bring about referral of alcoholics to specialized treatment centres in countries which do not have compulsory treatment of alcoholics, the idea of the treatability of the disease of alcoholism (or anyway of certain species of it) must be propagandized among the public at large, industrial concerns, TB sanatoria in particular, and also in general hospitals. This requires some degree of professional training of physicians, social workers and nurses, and a less formal indoctrination of teachers, clergymen, law enforcement officers, etc. Courses on alcoholism for medical students and training of interns is indicated.

The intensification of treatment services requires basic laboratory research and clinical investigation. It devolves upon the government clinics and hospitals for alcoholics to test a variety of treatment methods which have been developed in the past few years.

The Prevention of New Growth of Alcoholism and Other Drinking Problems

(a) If we talk about a total government program on alcoholism, we must consider alcoholic beverage control too. Such control either tacitly or overtly is intended to put the brakes on excessive drinking. Although alcoholic beverage control does not eliminate excess, and, therefore, is frequently regarded as entirely ineffectual, one must consider what conditions would be in the absence of the control of the distribution and sale of alcoholic beverages. Of course, the control agency dealing with

this matter is far removed from the agencies dealing with the treatment of alcoholics and with research on alcoholism, but perhaps greater effectiveness could be achieved through discussion between the treatment agencies and research departments on the one hand, and the control agencies on the other.

(b) Preventive education is one of the most important tools in this field. The government agencies must develop more and more activities in the education of young people as well as of adults, on the effects of alcohol, particularly in excessive amounts. These educational efforts must differ from those of the abstinence movement, particularly through the avoidance of the element of fear which in the past has greatly antagonized a large segment of the population. There is a need for more study of the content of educational materials as well as the manner of their presentation.

(c) A few recent studies of a sociological nature have shown that there are drinking customs and attitudes towards drinking and drunkenness which largely determine the incidence of excessive drinking and alcoholism. Too little is known about these customs and attitudes. It is evident that if we want to take recourse to applied sociology in the prevention of alcoholism and of other forms of excessive drinking it is only research which can supply us with the necessary tools and techniques.

General Considerations

It is seen that the various facilities which spring from the needs of a total program belong to various departments of government and some are of a semi-private or entirely private nature. There arises the question of how far one may go, and through what means one may achieve co-ordination among the various efforts and the various existing and potential facilities in bringing about their most effective utilization, as well as the greatest economy in terms of effort and finance.

II. PRINCIPLES OF ALCOHOLISM PROGRAMS

This section of the review is concerned with the principles and rationales of governmental activities in the field of alcoholism. It will serve as a summary although it appears at the beginning rather than at the end of the review. The comments on various measures are personal opinions of the reviewer, and are offered for what they may be worth.

The principles and motivations involved in the various aspects of alcoholism programs may vary from one country to the other and they may change within a given country in the course of time. Furthermore, certain terms used in one country may have a different meaning in the other one. It is of importance to examine the rationales and principles underlying such concepts as public care of alcoholics, compulsory treatment, alcohol education, "monopoly", license systems, and so forth. It is also of interest to examine the scope of the programs and the agencies or departments in which the administration of such programs is vested.

These considerations form the subject of the present chapter, but in order not to bog down in the philosophy of alcoholism programs the largest part of the present review consists of the description of the programs of given countries. The systems of Sweden, Norway, Denmark and Switzerland are each discussed in separate chapters as they seem of special interest to the Department of National Health and Welfare of Canada, and particularly to their Sub-Committee on Alcoholism. In order to avoid tedious repetitions of certain measures, a number of other countries are described in a common chapter. The chapter on Switzerland would seem to be of too great length for that small country, but it is a good example of a different type of "monopoly" from those of some of the Nordic countries, and it is also an example of certain inconsistencies in legal controls. The system in Switzerland appears to be appropriate for the illustration of the rationales underlying some elements which are common to many countries. Furthermore, in the matter of public care of alcoholics, Switzerland has a longer history than most other countries, and it also provides an instance of management of alcoholism programs in a country which has both a federal government and highly autonomous provincial governments (actually cantonal governments).

Public Care of Alcoholics

One may distinguish public care according to whether it provides compulsory care of alcoholics and some mandatory measures for other excessive drinkers or whether the government provides facilities exclusively for voluntary patients. The compulsory treatment may embrace, theoretically at least, all true alcoholics (Sweden, Norway, Finland, Switzerland), "dangerous alcoholics" only (France, Italy and some other

countries), or delinquent alcoholics (but not felonious alcoholics) whose minor misdemeanours are related to drunkenness. It also may apply exclusively to psychopathic criminal alcoholics (Denmark).

The expression "public care of alcoholics" may be applied legitimately whenever a legislative act makes it mandatory for government authorities to establish an agency for the treatment of alcoholics, irrespective of whether such treatment is compulsory or voluntary. In countries where the government not only completely subsidizes voluntary agencies for the treatment of alcoholics, but takes an active interest in their activities and may refer probationers to such agencies, one may also speak of public care, or at least semi-public care.

The compulsory treatment systems may have various motivations. One of the motivations is protection of the family and society in general without regard to the needs of the alcoholic. Such was the case in Sweden, Norway and Finland until recently; but now they also speak of the protection of the alcoholic patient. That this shift in motivation cannot be taken at face value is evidenced by the perfunctory application of psychotherapy and the still dominantly authoritarian ways in dealing with alcoholics and other excessive drinkers in these countries. On the other hand, in Switzerland the protection and the proper reintegration of the alcoholic into society is the primary motivation -- but not to the neglect of public safety and the interests of the family. Some of the Swiss Cantonal legislation on these matters goes as far back as the last decade of the 19th century. The decisive principle in such legislation is that the alcoholic is a helpless person, -- as helpless as a person afflicted with a psychosis -- and consequently requires protection which the law wants to achieve by declaring such a person a minor and placing him or her under guardianship. Such an idea is grounded in Roman law. Of course, placing a person under tutelage is an extreme restriction of personal liberty, and the Swiss therefore employ all possible safeguards in order to minimize the danger of abusing the compulsory treatment. In those Nordic countries where compulsory treatment is provided by law, the safeguards are not quite as stringent.

The effectiveness of "aid" measures, such as warnings, supervision and interdiction (blacklisting), as well as the nature of "treatment" in institutions for compulsory commitment, depend to a large extent upon the kind of alcoholic to whom such measures are applied. The low success rate in the recent past of Swedish, Norwegian and Finnish measures for persons with drinking problems and outright alcoholics may be ascribed to wrong assumptions made by welfare people about the etiology of the form of alcoholism which forms the predominant type in their countries. The assumption of the authorities in those countries is that they are dealing with people who have developed a bad habit and that such

a bad habit can be broken by the techniques with which other bad habits are tackled. The work of Aamark (1951) has shown that the predominant type of alcoholic in Sweden has many pre-alcoholic elements of high psychological vulnerability and that these elements must be taken into account in the various therapeutic measures.

In Switzerland, the same measures which show little success in the Nordic countries may be quite efficacious because the predominant type of alcoholic in Switzerland actually does arrive at his condition through noxious social habits. (There are nevertheless quite a number of Swiss alcoholics with high psychological vulnerability and in their case the measures do not work as a rule).

The idea of alcoholism as an illness is adopted and even written into the laws of quite a number of countries as may be seen in Chapters III to VII. In too many instances however this expression is only a matter of convenience, namely to compel health insurance agencies to cover the cost of the treatment of alcoholism. When it comes to the actual treatment, this concept of alcoholism is all too frequently forgotten. The acceptance of alcoholism as a disease necessarily implies a therapeutic approach. In the Netherlands, England (as far as the latter has any public care), Denmark, Chile, the U.S.A., Canada, and to some extent in Switzerland, Czechoslovakia, and Russia, the implications of the disease concept of alcoholism are duly considered. In many other countries the disease concept receives lip service.

It goes without saying that the commitment and treatment of alcoholics with psychoses in mental hospitals is carried out by all countries which have mental hospitals as well as an incidence of alcoholism. The matter of dealing with alcoholics with psychoses is not taken up here in the description of alcoholism programs.

Psychotherapy presupposes that there are psychological involvements in the etiology of alcoholism and that these elements require psychotherapy in order to remove them, no matter what kind of drug therapy may be used. In many public alcoholism programs psychotherapy is mentioned, but that does not necessarily imply that it is effectively applied. Group psychotherapy is sometimes used as a time saving element rather than as an appropriate technique for certain types of alcoholics. It must be considered, too, that although psychological disturbances may not be present in the pre-alcoholic state of alcoholic patients, such disturbances may develop in the course of the drinking career and require psychotherapy just as pre-alcoholic psychological disturbances do, except that in the former case a less formal supportive therapy may suffice.

The treatment of psychopathic criminal alcoholics is discussed in such detail in the chapter on Denmark that it needs no special consideration in the present chapter, except to mention the fact that the "treatment" of alcoholics in penal institutions is usually on a low level, unless such an institution is staffed by highly trained and qualified personnel.

Whether alcoholics should be treated in in-patient or out-patient services has been a matter of controversy for some time. This question has been largely solved by the exigencies of space, staff and finances. These limitations have resulted in a preference for out-patient clinics, while in-patient services, particularly in closed institutions, are being reserved for patients who have been committed for compulsory treatment, or in open institutions for patients who obviously need a short period of bed-care. In countries where the treatment of alcoholics is on a voluntary basis, the preponderance of out-patient clinics is motivated by the principle of initiating the treatment in the early stages of alcoholism. The early alcoholic who is still able to hold down a job is of course reluctant to be confined to an institution and thus be deprived of his ability to earn a living even for a period of a few weeks.

The treatment of the "early alcoholic" is a goal aimed at by most workers in the field. It is a moot question whether this objective is most effectively achieved through mandatory measures (the Nordic countries) or through the propaganda of voluntary organizations and of government agencies as in Canada and the United States. This reviewer is of the opinion that even where there are mandatory measures, a propaganda effort would greatly enhance the chances of reaching the early alcoholic and his family. Such a propaganda program must disseminate what knowledge we have of the prodromal signs of incipient alcoholism or of the exposure to the risk of alcohol addiction.

Unfortunately the designation, "out-patient clinic" has been attached frequently to agencies which have no clinical character but which are merely centres where alcoholics and others with drinking problems are told not to drink or are placed under supervision and blacklisted from drinking places. Such is frequently the case in "clinics" operated by temperance boards or temperance committees in countries which have compulsory treatment. If those authorities believe that they are intercepting incipient alcoholism, they are greatly mistaken.

The Swedes are inordinately proud of their laws which "make it possible to detect and to aid the early alcoholic". They believe that their legislation on this matter is unique and they urge other countries to adopt it. If they would orient themselves objectively on the alcoholism activities in other countries they would change their minds about the

uniqueness, as well as on the high effectiveness, of their procedures. Furthermore, they disregard the fact that in countries which have a federation of autonomous units (States, Provinces, or Cantons) such matters as the public care of alcoholics are not vested in the Federal Government but in the government of the autonomous units, although the central government - as in the case of Switzerland - may have a consultative body dealing with this question. Nevertheless as the example of Switzerland shows, a Federal or National body which functions as a clearing house, and which has no administrative but purely consultative functions and some research activities - may be of great utility.

There is always the question of which government should be in charge of the management of excessive drinkers and alcoholics. Should this field belong to Welfare or to Public Health or to some other Ministry? (In Brazil the Federal sub-committee on alcoholism is under the Ministry of Foreign Affairs). In Poland the administration of the alcoholism clinics and even the control of the sales of alcoholic beverages belongs characteristically to practically every Ministry in the cabinet. The principle there is that in order to make the treatment of alcoholism available to people in all walks of life, every Ministry should have its special responsibilities.

For comparative purposes it may be profitable to take a look at Yugoslavia with its many component parts. In Croatia the management of alcoholics is carried out by the Health Department particularly through its School of Public Health, while in Serbia and Slovenia these matters are initiated by the Red Cross. In the latter two states of Yugoslavia the public care of alcoholics is not quite efficient but in Croatia these matters, with a few exceptions, are in rather good shape. Nevertheless a general rule cannot be recommended. Local circumstances must be carefully considered, always with the understanding however that a certain degree of medico-psychiatric care is necessary. The example of the Netherlands would indicate that properly trained psychiatric social workers can carry efficiently the burden of psychotherapy if they are properly supported and guided by consulting psychiatrists and other medical consultants. Where the social worker staff is not trained in psychiatry and medical social work, the system is liable to be less successful.

The training of clinical personnel is discussed in the subsection on education, but it must be mentioned here that expansion of hospital and clinical facilities for alcoholics cannot be thought of without the specialized training of physicians, psychologists, social workers and nurses in the treatment of alcoholics. Likewise research cannot be arbitrarily separated from treatment, but an orderly discussion demands such arbitrariness.

It would seem from an acquaintance with the conduct of treatment clinics for alcoholics that the best results are obtained where such clinics are under the jurisdiction of a government department which has experience with the administration of hospitals and clinics in general, i.e., either a mental health department or a public health department and in some instances affiliation with medical schools. (In some countries, public health is a division of Welfare Ministries).

As the number of alcoholics is rather great, the burden of treatment must be shouldered to a large extent by trained psychiatric social workers, but of course under the guidance of psychiatrists and other physicians. Co-operation with Alcoholics Anonymous groups has also shown great advantages in several countries.

It may be pointed out in the present section that "first-aid" to alcoholics has proven itself extremely useful in Amsterdam. In that city a psychiatrist or psychiatric social worker is called to the spot where an alcoholic is causing a disturbance and thus is in a position to obtain an impression of the role of the immediate environment in the behaviour of the alcoholic patient.

Educational Activities

Education in the field of alcoholism may have various objectives which all require due consideration. Nevertheless, some countries concentrate on one or two aspects only to the neglect of the other requirements of "alcohol education".

On the North American continent the main emphasis has been on alcoholism as a disease and its treatability. This aspect of education covers only the prevention of the growth of existing alcoholism and other drinking problems, but does not take into account the prevention of new growth. The latter aspect is practically left to temperace societies which utilize the element of fear rather than of prudence. On the other hand, in most European or South American countries, little if any effort has been made to propagate the idea that alcoholism and other drinking problems are accessible to psychiatric-medical treatment. Instead they concentrate on the evil effects of alcohol, in much the same manner as temperance societies, i.e., the total abstention movements. Educational activities should cover both aspects.

Where there is no compulsory treatment there is little hope of reaching all the alcoholics in a given country without propagating the treatability of the many species of alcoholism. Even Alcoholics Anonymous does not reach more than 0.5 per cent of the alcoholic population in any given area. This weakness of the educational effort would suggest among other things that no proper modus of communication has been evolved by

the educators on matters of alcohol and alcoholism. It would seem that we have a set of language which is appropriate for a small section of the population only. Actually several sets of language must be developed in order to penetrate all strata of the population. In order to be able to communicate effectively with a heterogeneous population on these matters we need research on communication. This is another example of the interrelation between treatment, education and research. The difficulty of communication makes itself felt even among workers in the field of alcoholism in any given country and more so in international communication.

Another thing often overlooked - and this concerns the prevention of new growth of alcohol problems - is an effort to educate not merely on the noxious effect of large alcohol intake, but to point out the risks of certain drinking customs and attitudes toward drinking. Such an effort should not be left to guesses, but should be based on factual knowledge which can be achieved only through research. The few field studies which I have carried out on drinking patterns and customs have shown me that the incidence of alcoholism in various countries is to a considerable extent assignable to differences in drinking customs and attitudes towards drinking. Thus we should not reply exclusively on the physiopathological effects of large alcohol intake, but should also take recourse to what may be termed applied sociology. Nation-wide surveys on drinking patterns and attitudes are in order. The interrelations of treatment, education, research and sales and production controls are manifested in the increasing trend to include all of these activities in a single legislative act (see the sections on Sweden, Norway, Poland and Chile).

The educational activities of a government program on alcoholism fall into four main categories: (1) formal training of clinical personnel, (2) brief instruction courses for professional and vocational groups whose members may have occasion to deal with alcoholics, (3) information for the public in general (youths and adults), and (4) information particularly oriented towards alcoholics and their families.

Formal training courses are devised largely for creating the necessary personnel for the expansion of clinical facilities for alcoholics and the provision of one or two specialized physicians for general hospitals. In Sweden such training courses are provided by law, but their contents and intensity are not described. In the Netherlands, courses for physicians, psychologists, social workers and nurses who wish to specialize are organized by the Association of the Consultation Bureaux and concentrate largely on lecture courses of over 100 hours with little emphasis on clinical demonstration. In Chile, on the other hand, training courses of 3 to 6 months in the excellent clinics of Santiago are provided for one

physician and one social worker from each of the 22 health districts of that Republic. The number of lectures in this latter training course are held down to 10 or 15 hours. The lecture courses include lectures on alcohol education by properly qualified health educators.

Slowly some treaching on alcohol and alcoholism is being included in the undergraduate medical curriculum, but with the exception of the Nordic countries and Chile, it remains far behind such efforts in the U.S.A. and Canada. (It may be mentioned that the Quarterly Journal of Studies on Alcohol, Vol. 22, No. 1, pp. 135 to 142 contains a report on a survey of teaching on alcoholism in the undergraduate medical curriculum, in Canada and the U.S.A. which is well worth reading). It would seem highly desirable to foster the teaching of this subject to undergraduate medical students, in a course of at least six hours plus one day at a specialized clinic.

The formal post-graduate course for physicians, social workers, and nurses who wish to specialize in alcoholism should include (in this reviewer's opinion) at least three months clinical work and at least 12 hours of lectures. Of course participation in clinical staff conferences is taken for granted in stipulating such a small number of lectures. The latter should include instruction on the pharmacology, biochemistry and pathology of high alcohol intake.

The brief course for the orientation of physicians on the subject of alcoholism may be restricted to a seminar of two to three days, if possible at a medical school, and provide for postgraduate credits. The object of such a seminar is to give hospital physicians sufficient instruction on alcoholism to enable them to talk with alcoholics who need a physician's guidance to seek treatment of their alcoholic habits. Similar, but less technical seminars are desirable for psychologists, social workers and nurses. Even briefer courses should be provided for law enforcement personnel, the clergy and industrial personnel mangers. "Refresher courses" may be given in order to keep up the interest in this subject.

The question of educating the public in general, and youth in particular, is a controversial one. In Sweden and Norway, the official attitude is education for total abstinence at least for the period of adolescence, i.e., up to the age of 21 years. This is of course a fully justified stand as the sale of alcoholic beverages to persons below that age is prohibited by law in those countries. This is also the law in Canada and in most states of the U.S.A. too and thus insistence on total abstinence for young people would be in accord with the liquor control laws of those countries. The question is how to present this instruction -- with what materials and in what manner. Instead of basing the teaching on elements of fear,

prudence should be invoked. The teaching must be in full agreement with scientific facts, and the designation of alcoholic beverages as poisons must be avoided. A differentiation between alcohol and alcoholic beverages must be made and the whole matter must be presented in its social and psychological context. It does not seem desirable to me to single out teaching on alcohol and drinking as a special subject, but rather to discuss it within the frame work of nutrition and mental health. In those instances the drinking would not seem to be dragged in by the hair, but would merge as one of the important elements of the main subjects under discussion. Reasonable teaching on this subject can be expected only if the subject is taught in teachers' colleges, and there too not as a separate subject but either in connection with physiology or nutrition or in relation to mental health.

Lastly, if the goal of an official alcoholism program is the treatment and rehabilitation of all alcoholics within a country or its constituent Provinces or States, there must be a propaganda effort to make treatment acceptable to the alcoholic, his family, associates and employers. This is desirable even where compulsory treatment exists. The disease concept is a helpful one in this relation, but care must be taken that this concept should not remain too vague. Nor should one take recourse to much sentimentality and place a halo on the head of the alcoholic as is often the case in the propaganda of voluntary agencies.

Research Activities

Research is indispensible to progress in the treatment of alcoholics and to the prevention of alcohol abuse. Thus it may be said that research is a central activity of alcoholism programs, whether governmental or voluntary. Nevertheless it is not the sine qua non of any provincial or state program as long as at least one of the provinces, states or equivalent political units has an elaborate research set-up or a national research centre is in operation or acts as a consultative body in matters of scientific investigation. Sweden, Norway, Finland and Chile have national research institutes. In Switzerland the Federal Committee against Alcoholism acts as a consultative agency and occasionally carries out research projects of its own or subsidizes research. In France the Haut Comité d'Etude et Information sur l'Alcoolisme serves as a documentation centre and fosters research through grants to competent and interested persons at universities and hospitals.

Generally, it may be stated that a research institute on alcoholism should be either part of a university (Sweden, Chile), closely affiliated with one (Norway), or have some connection through research workers who also have university appointments. In countries where there is intensive research activity by independent research workers at various universities

and hospitals, the matter of a central research institute on alcoholism is not of prime importance, but it encourages the work of independent investigators. Central agencies may be operating ones or they may subsidize outside research or they may embrace both of these procedures.

Various questions arise in large central research institutes. For one thing should research be regimented or should one gamble on the ability and know-how of individuals? On the North American continent there has been a trend toward regimentation under the guise of co-operative research. Good research is produced by able researchmen rather than by research directors. An outstanding nuclear physicist said: "buy the time of an able man, and then give it back to him." This principle seems to be a sound one. Nevertheless, if there is a gap in research it would seem legitimate to stimulate interest in that subject and then hire an able man to carry it through. The Research Department of the (Ontario) Alcoholism and Drug Addiction Research Foundation in Toronto is proof of a research program's evolving out of the association of able researchers without any obtrusive program machinery.

Another question is whether such research institutes should engage entirely in practical, i.e., applied, research or whether basic research should be considered too. This would seem an idle question, as there is no applied research without basic investigations behind them. Much of applied research arises in the field which is designated as clinical research and much of that is too undisciplined to be of any value. The research department can act as consultants to the clinical investigators. The best research men have had apprenticeships for shorter or longer periods with highly experienced investigators. A training program should not be limited to the production of clinical personnel but should provide also research apprenticeships.

While, as stated before, in a country which has many independent research workers, a central research institute is not indispensable but a central documentation service is essential in order to facilitate the work of scientific investigators and to save their time for more productive activities.

The trend of research projects in the Nordic countries has been toward an increased interest in the socio-cultural elements of alcoholism and any other form of drinking, drinking patterns and customs. Such studies are of paramount importance in preventive education and have bearing even on the treatment of alcoholics. In order to be of the greatest utility these investigations should be carried out nationwide. Recently the Scandinavian countries together with Finland have established close contact of their research workers in the field of alcoholism.

The biological investigations are tending to move from peripheral studies on alcohol effects towards possible physiopathological elements in the etiology of the various species of alcoholism.

Special mention must be made of a long neglected gap in alcoholism research, namely the study of identical twins. This gap is now being filled through the extensive and intensive study carried out by the Finish Institute of Alcohol Research. (For details see R.E. Popham's Sub-study 3 - 2 - 60 -- page 88.) A smaller study of this subject was published in 1960 in Sweden.

Alcoholic Beverage Control

Ever since the production of alcoholic beverages has passed from the hands of the housewife to production by a recognized trade, there has been some regulation of the sales of such products in wine shops, taverns, etc. There has been much scepticism concerning the efficacy of control laws, but one may wonder where we would be without them. A government program on alcoholism cannot be thought of without a certain regulation of sales. No matter under what label such regulations come, they must tend to limit the excessive use of alcoholic beverages.

There has been much discussion of the value of "sales monopolies" versus systems based on "licensing" only. Such discussions are made particularly difficult because the term "monopoly" means one thing in one country and something else in another. There is perhaps no absolute sales monopoly in any country, since sooner or later licensing, even if rather limited, is introduced for "on-premises" consumption. Government monopoly in European countries was based on the idea that it eliminated the element of profit. On the other hand in some countries a production monopoly of spirits served primarily the purpose of government revenue, e.g., in Tsarist Russia. As a matter of fact, in some countries which had production monopolies, sales licenses were often rather lax. However, in some countries the sales monopolies (and limited production monopolies) are of high standards and the licensing of "on-premises consumption" (in hotels and restaurants) is very well controlled. The Swiss "alcohol monopoly" covers the production and wholesale of certain spirits only and does not extend to retail by the bottle. The "monopoly" in this latter country tends to safeguard against the indiscriminate use of potatoes for distillation purposes. Furthermore through the subsidy granted by the Swiss Alcohol Monopoly to vineyard and orchard owners, it has become possible for these owners to market unfermented "wines" and ciders without any financial loss. This procedure has contributed more toward the acceptance of unfermented fruit juices than any direct propaganda could have achieved. In addition the Swiss government, and later the Swedish and Norwegian governments

have subsidized alcohol free restaurants - which operate without loss. The encouragement of such establishments and of the production of unfermented "wines" and ciders could be introduced in any wine producing and cider producing country. The key to that is not in such propaganda as "drink more fruit juices" but in the fact that the producers are enabled to market their products without loss and at a reasonable price. The fostering of alcohol free restaurants is, of course, of importance only in those countries in which nearly every restaurant has a license for "on-premises" sales.

The main measures for cutting down the excessive use of alcoholic beverages are of many kinds, some of which should be mentioned here.

In England the curtailment of "business hours" in pubs has undoubtedly contributed to a decrease in drunkenness and alcoholism, although not all of the decrease may be attributed to this measure. It is also open to question whether this type of control could be effectively transplanted into other countries.

There is also a limitation of the number of sales outlets in relation to the population size of cities and towns. It may be noted that such limitations have an effect on excessive consumption only in the extreme. (It seems to make little difference whether there is one outlet for each 500 or each 1000 heads of population; but there is a distinct difference in consumption as between jurisdictions where there is one outlet for each 100 and one per 4000 of population.) The difference is not so much accounted for by ubiquitousness and greater accessibility of alcoholic beverages than by the fact that where the number of outlets is very great there is a tendency for undesirable competition. Where the competition is great licencees may tend to squeeze every nickel and serve minors and drunks in spite of regulations to the contrary. The number of outlets in relation to population is of more importance in the case of "on-premises" licenses than in the case of package stores (off premises consumption), although in the extreme the too great accessibility and the element of competition (not in sales monopoly states) may contribute to abuses. It may be mentioned here that one of the most undesirable forms of license is the "over the street sale" which makes it possible to buy small quantities of spirits in a tavern or bar and to carry such purchases to the home. This type of license is found in several European countries, e.g., the Netherlands, Austria and surprisingly in Switzerland, a country which very definitely wishes to limit consumption of alcoholic beverages through sales controls.

There is great interest in the question of price differentials for beer, wines and distilled spirits, either indirectly through taxation, or in monopoly countries directly through price policy. Studies of the results of price controls may be conflicting as the results may depend

upon whether or not the price is determined in relation to the standard currency unit of a given country and to disposable income. An effective price policy must take these two latter elements into account. The price will perhaps not deter the confirmed alcohol addict, but it will have a definite effect on other varieties of excessive drinking and thus serve as a preventive measure for new growth of alcohol problems. In Denmark and Switzerland high prices of distilled spirits arrived at through taxation or otherwise, have had their effect on the consumption of that commodity, but as soon as inflation brought about high prices for all commodities and an increase in disposable income, the restricting effect on the consumption of spirits vanished. The differential price policy of course aims at diverting the consumption to beverages of low alcohol content. It would seem to be essential that in such measures the absolute alcohol of the same volume as contained in beer and perhaps in ordinary table wines should be substantially less expensive than that contained in dessert wines - sometimes referred to as fortified wines - and in distilled spirits. This comment does not imply that there are no beer alcoholics, but in the experience of the present reviewer, very few drinkers develop alcoholism from beer drinking, but many alcoholics turn from spirits to beer and continue to be alcoholics in spite of beer consumption.

One interesting instance of price differential is contained in the Vanderwelde law of Belgium which not only fixes a high price on distilled spirits, but make it doubly more expensive through the stipulation that it cannot be sold in amounts of less than two litres, and excludes it from on premises sales.

Summary of Points of Social Interest

1. The ultimate goal of any government program on alcoholism must be the treatment of the entire alcoholic population, primarily in outpatient clinics.

This involves:

(a) Intensive training of clinical personnel for three to six months in specialized clinics and a lecture course of 12 to 15 hours.

(b) Obligatory course on alcoholism within the undergraduate medical curriculum (six-hour lectures and two-hour clinical demonstration).

(c) Brief orientation courses for law enforcement officers, social workers, clergy, nurses and industrial personnel managers and, if possible, for certain officers of the armed forces.

(d) A well devised propaganda campaign on the treatability of alcoholics and this involves:

(e) Research on proper communication about alcoholism for various strata of the population, in order to bring alcoholics to the expanding clinical facilities.

(f) A special effort to reach incipient alcoholics. Among many possible measures one might be to make the restoration of withdrawn drivers license (e.g. "driving under the influence") contingent upon visiting specialized clinics and obtaining a diagnosis and prognosis.

(g) An enabling paragraph on compulsory treatment to which recourse may be taken when all other measures fail, and when the alcoholic is a threat to his family. (Proper safeguards against abuse).

(h) The wide utilization of psychiatric social workers and psychologists under the guidance of psychiatrists as counsellors for alcoholics. With the growing number of alcoholic patients there is no adequate number of psychiatrists to take care of them. (The training of the counselors comes of course under point 1 (b).)

(i) A clinical effort to distinguish between the various species of alcoholism in order to arrive at the most suitable treatment for the patient in question.

(j) A recognition of the fact that all alcoholics impair all aspects of their metabolism (commonly subclinical damage) and that unless the discomfort arising from such impairment is relieved through medical treatment, the chances of psychotherapy are curtailed.

(k) Fostering of "half-way houses" managed by suitable personnel.

(l) The desirability of relating alcoholism agencies to Public Health or Mental Health Departments rather than to Welfare Departments.

2. The introduction of courses on alcoholism into the curriculum of teachers' colleges.

(a) Teaching on alcohol and alcoholism in public schools in connection with the discussion of nutrition and mental health rather than as a special subject.

(b) An effort to eradicate undesirable drinking customs through education.

(c) In adult education particular emphasis on the treatability of alcoholics.

3. A National Institute on Alcoholism and Addiction to other Drugs, including a documentation centre. In this connection it may be noted that there is an increasing tendency in Europe to extend the work of alcoholism agencies to research on and treatment of addictions to other drugs. (Norway, Sweden, Belgium).

(a) A nationwide survey of drinking patterns and customs which may be best carried out by a Department of Mental Health or by a National Institute on alcohol studies.

(b) Research on multiple addictions (alcohol in combination with barbiturates and tranquillizers), and substitution of one addiction for another one.

(c) Research fellowships are desirable in order to provide able research personnel for growing needs.

(d) The research departments of alcoholism agencies should have some ties with universities.

4. In countries with sales monopolies the question of the number of government liquor stores does not seem to be a particularly urgent one but, of course, there must be some definite differential policy on urban and rural sales. On the other hand, the granting of licenses for on-premises sales ought to be governed by the principle of not creating undue competition.

(a) Price policy needs serious consideration and should be related to the standard dollar and disposable income. The price of one ounce of absolute alcohol contained in beer should be somewhat lower than one contained in ordinary table wine, substantially lower than one ounce contained in dessert wines (14 per cent and over) and particularly than in distilled spirits. The prices should be revised from time to time in accordance with the above factors.

(b) The fostering of alcohol-free restaurants would seem to be of importance only in those countries in which most restaurants have an on-premises license.

(c) The increased use of unfermented "wine" or fruit juices can be furthered best through subsidy to vineyard and orchard owners to enable them to sell such products without loss at reasonable prices. In the absence of such subsidies, propaganda for greater use of unfermented fruit juices does not seem to be of particular efficacy.

5. A total alcoholism program of a government would seem to require some coordination of all matters which have some relation to the use of alcoholic beverages irrespective of the government department to whose jurisdiction the specific matter may belong. There has been a tendency to bring all these matters into one piece of legislation. (Norway, Sweden, Chile).

III. SWEDEN

In 1954 an act embracing all aspects of "temperance" was passed and came into effect towards the end of 1955. Swedish alcoholism literature, except for research papers, is still concerned with the description and evaluation of the results of the reform act, particularly the consequences of abolishing personal purchase books. The following descriptions are mainly based on a booklet issued by the Swedish Temperance Education Board (1960) [1] and a 1960 lecture (mimeographed) by Mr. Daniel Wiklund [10]. Several smaller papers concerning the effects of the control reform are taken into account as well as notes by Dr. John Armstrong (1959). [9] The present reviewer's comments are based on personal observations and on correspondence with Swedish students of alcoholism.

Public Care of Alcoholics

The first Act concerning alcoholics was passed in 1913, but there were some earlier efforts in this direction. In principle, the basis of this early legislation was 'protection' (of society) with little consideration for the alcoholic. Furthermore the law was only applied to addicts. In a subsequent Act, passed in 1931, the treatment aspect of alcoholics played a greater role. The present Act, adopted by Parliament in 1954, and compared with earlier legislation, provides a much wider field of action for the public care of alcoholics, because among other things it permits the community to intervene at a comparatively early stage of alcoholism.

The legislation provides for local committees for the prevention of alcoholism and the treatment of alcoholics. These are called local temperance committees and they are appointed by local authorities in every urban and rural district. There are also temperance boards in every county. The local temperance committees consist of at least five members, one of whom "if possible" should be a physician.

According to the intention of the law the local temperance committees should provide general activities for the furthering of temperance, give advice and information in connection with the tasks of the committee, and determine from case to case "psychologically suitable treatment aimed at removing the reasons for alcohol abuse". They should "place into care" "alcohol-abusers" of various kinds, and they should handle problems concerning road traffic and alcohol. The county temperance board, besides undertaking tasks similar to those of the local committees, must also supervise and help the local committees. The local and county bodies alike are supervised by the National Social Welfare Board of Sweden. The State defrays 75 per cent of the costs of the local temperance activities and the total cost of the county temperance activities. In 1958 the total cost of the local temperance activities was about 19 million Swedish Kroner.

Section 1 of the Act of 1954 states the conditions under which the boards should interfere in the individual cases: "Steps shall be taken to bring any person who abuses alcoholic beverages back to a sober way of life. Abuse of alcohol is deemed to exist when a person consumes, not merely occasionally, alcoholic beverages to such an extent as to cause himself or others obvious injury". As soon as the local temperance committee has become aware of a person's abuse of intoxicating liquors, whether by information from some authority (e.g. the police), by information presented by a private person or through the committee's own observations, the committee must make an investigation.

Section 14 of the Act says: "If the local temperance committee's investigation shows that the person in question abuses alcoholic beverages, the committee shall, whenever desirable and useful, endeavour to convey to him an understanding of the danger of alcohol abuse and shall apply on his behalf suitable welfare measures, such as to endeavour:

(1) to persuade him to keep in continuous touch with the temperance committee or its office, or a person appointed by the committee, for a certain period of time, not to exceed one year;

(2) to help him to obtain suitable employment or, with a view to diminishing the temptation to consume intoxicating beverages, to obtain for him a change of work or dwelling;

(3) to persuade him to avoid visiting places where alcoholic beverages are served;

(4) to induce him to join a temperance organization or other suitable society;

(5) to persuade him to consult a doctor and to follow his advice or voluntarily to seek other suitable treatment."

As will be seen, the measures in accordance with section 14 are of such a nature that they presuppose the client's voluntary co-operation and are therefore to be regarded as "measures of aid". The board may prescribe a comprehensive treatment scheme which takes into account differential factors in the etiology of "alcohol abuse", as well as the special needs of the individual.

In certain graver cases, some compulsory treatment may be required, but may not be applied unless investigation shows that the individual is "addicted to the abuse of alcohol" (general indication) and has been found to display certain behaviors referred to in Section 15 of the Act as "special indications". Thus the abuser of alcohol must, on account of his drinking habits (addiction), either:

"(1) be a danger to another person's security or bodily or mental health or to his own life, or

(2) expose a person whom it is his duty to support to suffering or obvious neglect or otherwise fail in his duties towards such a person, or

(3) become a burden to the community, his family or other persons, or

(4) be unable to take care of himself, or

(5) lead a life that is seriously disturbing to his neighbours or other persons, or

(6) have been convicted on at least three occasions during the past two years of drunkenness or certain other minor offences committed under the influence of intoxicating liquors, or

(7) without striving honestly to support himself, leads a vagrant life."

A person referred to in this section of the Act may be subjected to supervision for a maximum period of one year - in special cases two years - and a special supervisor must be appointed. In certain circumstances, individuals may also be detained in public insitutions for alcoholics. It is becoming more and more common, however, to arrange for more advance "open" or out-patient clinical treatment. Cases covered by Section 15 may be forcibly detained if aid or supervision has failed to restore the individual to a sober way of life, if aid and supervision would clearly be useless, or if attempts to apply aid or supervision cannot, in view of the dangerous condition of the individual, be applied. According to Swedish authorities only a relatively small group of alcoholics need compulsory treatment. Institutional treatment may also be provided for persons who voluntarily wish to take advantage of such treatment.

Application for detention is to be made by the local temperance committee to the county administration and must be accompanied by a report of the investigation, an extract from the parish register and a medical certificate. The duration of the institutional treatment according to the Act is one year in the first instance and two years in case of a relapse. Voluntary residence may be requested by the individual for a certain duration, but may not exceed one year. As a rule, the patients are granted so-called probationary leaves long before the expiration of the period of institutional treatment. Thus treatment of first-admissions

usually covers a period of three to four months. During probationary leave the client is usually placed under supervision and may also be required to submit to certain pledges of obedience. Treatment in the institution must be governed by the principal aim of all treatment - to restore the patient to a sober way of life - and includes such items as "anti-alcohol treatment" and the breaking of drinking habits, occupational therapy and other quasi psychotherapeutic influences. In addition, attempts are made to deal with the patient's social, economic and personal situation. The individuals are differentiated with regard to sex, age, state of health and previous criminality. On December 31, 1959, there were in Sweden 32 public institutions with a total of 2,023 treatment beds. The best known is Venngarn, with 185 beds, for alcoholics with criminal records (Kälstrom, 1959)[4]. Reportedly there has been a tendency to make treatment more active in the various institutions. The new legislation works toward improvement of all treatment. The State covers the entire cost of operating the public institutions.

Apart from the public institutions there are 14 private institutions with about 300 beds, which have the character of convalescent homes. At these institutions only voluntary patients with a good prognosis are received. The patients pay a small charge, but the State defrays most of the cost.

In some cities there are "half-way houses". This type of treatment is said to have been of great utility, particularly as it is possible to keep the inmates at work in their usual places of employment while treatment and supervision are being carried out. They can thus support themselves and their dependants. Sometimes this type of treatment is resorted to as aftercare for certain institutional cases.

To make medical examination and treatment available, the government has recommended that local temperance committees establish and administer out-patient clinics for alcoholics. In order to stimulate such public consultation and treatment centres, the state makes a grant towards the establishment and maintenance costs. This grant is equal to that made for other branches of the committee's activity. In several large towns the temperance offices have recently begun "intensive clinical treatment of alcoholics". At present there are about 125 out-patient clinics in operation. About half of them are run by the local committees while the rest are administered by public health services or privately. In several cities there are, aside from the ordinary temperance offices, also special temperance offices intended only for voluntary patients.

The recommendation that the local temperance committees should "if possible" include a physician in their membership, casts some doubt upon the competence of these committees to diagnose, counsel and generally help a true alcoholic. The provisions regarded as "aid measures"

do not presuppose merely voluntary cooperation on the part of the patient but appear to imply that they are not true alcoholics, but rather undisciplined heavy drinkers who still have a free choice in the matter of drinking and will make the right choice if the Damocles sword of more restrictive measures hangs over their heads. If the majority of the clients of local temperance boards in Sweden consist of such heavy drinkers who are not true alcoholics, the measures mentioned above may serve to prevent their progressing to one or the other species of true alcoholics. In that case these procedures are worth while ones. The question arises again however as to whether or not the local temperance committees are competent to make a differential diagnosis between a true alcoholic and merely an undisciplined heavy drinker.

In the recent past, procedures which were regarded as "treatment" by the welfare minded temperance committees and their staffs as well as by the staffs of State Institutions for alcoholics hardly warranted the designation of those measures as therapy. The procedures at the "clinics" of local temperance committees and in the State Institutions had an authoritarian character rather than a therapeutic one. It is therefore highly welcome that the Temperance Act of 1954 recommended measures which truly constitute a therapeutic approach. The recommendations of this Act will surely be adopted in the State Institutions for alcoholics and by the temperance committees in the larger cities; but their application in smaller communities - and these constitute the largest number of local committees - will not be possible even though the state government grants additional subsidies.

That such true therapeutic measures have come so late in Sweden is astonishing in view of the fact that the country has psychiatrists of very high qualifications who understand alcoholism and its treatment and who have made significant contributions in these fields. Evidently these outstanding psychiatrists and some other medical men interested in alcoholism were not able to penetrate the field which welfare workers arrogated as their own. The 1954 Act would indicate that at last the medical experts on alcoholism and its treatment have made a dent on the public care procedures. It is also possible that the Swedish public authorities, who were always so proud of their "superior handling" of alcoholics, have come to realize that some other countries have also been active in the field and that far from their being inferior, had something to offer even to Sweden.

When one speaks of the quality of treatment for alcoholics in Sweden, one should always state whether one has public insitiutions or university clinics and their affiliates in mind. The universities have always ranked high in these matters, the public institutions shone only in the eyes of welfare workers. Among the outstanding psychiatric hospitals and

out-patient clinics which admit alcoholics either for in-patient or out-patient treatment are Sodersjukhuset, Iongbro Sjukhus, and the Stads Informationsbyra, all located in Stockholm. In all of these hospitals and clinics a great deal of Antabuse and tranquillizers are administered, but psychotherapy is by no means neglected.

Alcohol Education

It is an old tradition in Sweden that the state should support educational activities concerning the alcohol problem. As early as the 1840's, the Swedish Parliament made grants to temperance societies for lectures and distribution of pamphlets. In 1901 the temperance movement founded the Temperance Education Board. One of the main tasks of this body was the organization of courses for teachers on the alcohol problem and the provision of an ample supply of textbooks, handbooks, and school materials for instruction on the alcohol problem. These activities have long been supported by the state and are now almost exclusively paid for out of state funds. In 1919, education on the alcohol problem was made part of the field of activity of the highest school authority, the Board of Education. The rules now in force are those provided by the Reform Act of 1954.

The commission which prepared the reform legislation of 1954 stated that there were defects in the instruction on the alcohol problem given by schools as well as in other educational activities. An interesting detail in the report is that the commission expressly states the opinion that it is in the best interests of society that there should be a temperance movement on a total abstinence basis. On the one hand it was found to be advantageous to society that as large as possible a portion of the population should not use alcohol, as better social conditions might be expected to result from this. On the other hand, the commisssion pointed out that the temperance movement, through its various activities, could spread information on the alcohol problem among the general public to a much wider extent than would be possible if the state itself were to organize such educational activities.

The educational activities are still under the supervision of the Board of Education, in which there is a department for adult education. Most of the work outside the schools, however, is done by voluntary organizations, and the Board merely distributes the financial aid provided by the state and sees to it that this money is used for the purpose for which it is granted. Of course, when it comes to instruction in schools, the Board takes a more direct responsibility. In order to guarantee that the interests of temperance education shall be respected, there is a consulting member of the Board, who is employed on a part-time basis and who takes part in the handling of any matter touching upon the alcohol

problem. In addition to the Board of Education there is also the Temperance Education Board, which is a centre for ideas and initiatives concerning Swedish Temperance work.

As for the instruction given in schools, there are now regulations for what pupils in the various types of schools shall be told about the effects of alcohol. In the educational curriculum of 1955 for elementary schools it is stated that schools should instruct the pupils on the most common narcotics and stimulants; among the former, particular stress is to be laid on alcohol. For each school grade the material to be presented is specified. This instruction should mainly be given within the context of courses on natural science and social science. In connection with the instruction on natural science the effects of alcohol on the human body should be treated with special reference to the risks of the influence of alcohol on drivers. In social science courses the harmful social effects of drinking should be dealt with. The teacher should also talk about the temperance movement and its reasons for advocating total abstinence, and about the measures taken by society against the evil effects of drinking. The effects of alcohol should also be dealt with during instruction in gymnastics and home economics. In connection with sports and games, the risk of using alcohol and tobacco should be stressed. In the course on home economics the teacher should point out that it is possible to use non-alcoholic fruit beverages instead of wine on festive occasions.

What applies to the elementary schools, on the whole, applies also to the high schools. For high schools regulations of a similar kind have been issued, adapted of course to the higher age of the students. In elementary schools the most important part of the instruction on the alcohol problems is given in grades 6-9. In 1959 the Board of Education sent a circular to the schools recommending that instruction on the alcohol problem should be dealt with earlier than is expressly provided in the syllabuses. At this early stage it should not be a question of systematic instruction but rather of "suitably formulated warnings against the abuse of alcohol", with special stress on the risks that alcohol abuse involves in the years of adolescence.

An important prerequisite for the results of temperance education is, of course, that the teachers should have a sufficient knowledge of the subject and should take a real interest in this branch of education. In order to guarantee this, the temperance education at universities and teachers' colleges has been improved.

In 1959 there was published in the Board of Education's series of publications a guide for teachers, entitled "Instruction on the Alcohol Problem in the Schools" prepared by the Board. This book is divided

into two main parts: "I. Physiological Effects of Alcohol", and "II. Alcohol and the Community". The book also deals with the pedagogical and methodological aspects of instruction on the alcohol problem. Textbooks on natural science and social science are not approved for use in the schools unless the books deal with the alcohol problem in a satisfactory way. (The schools choose their textbooks from a list approved by a special state board.)

Instruction on the alcohol problem should also be given in vocational and professional training, "whenever there are reasons for such instruction". There are similar regulations concerning the training of physicians, social workers, and police personnel. Military temperance education is also foreseen. During the one year of military training trainees attend lectures and see films on the alcohol problem. The recruits are handed a small pamphlet giving the basic facts on alcohol. Officers and non-commissioned officers in training get a more thorough course on the alcohol problem based on a handbook that was worked out in cooperation with the Temperance Education Board.

Some persons actually engaged in temperance education in Sweden feel it is proper to state that in reality, Swedish temperance education does not always live up to all the "admirable schemes" that are set forth in the various regulations. The principles involved in temperance education may run counter to the convictions of quite a few persons who are supposed to implement the "admirable schemes".

An innovation of the 1954 reform is the so-called special subsidy for which temperance organizations and others may apply to the Board of Education, to cover the costs of educational projects on alcohol education.

In summary it may be said that in Sweden instruction on the alcohol problem is given (1) as part of the ordinary curriculum of schools and (2) as educational activities directed towards the general public. The latter are organized partly by the Temperance Education Board, partly by the temperance movement with the support of other national movements. At present the State spends approximately two and a half million Swedish Kroner per year on temperance education.

All this teaching, which is oriented towards total abstinence and which has been carried out systematically for 60 years (although not with all the refinements of the 1954 legislation), has not produced a relative increase in the abstaining population of Sweden. As a matter of fact, there has been quite some shrinkage in the percentage of total abstainers. At present 34 per cent of Swedish adults fall into that class.

Research

Swedish research on the effects of alcohol and on alcoholism has a long and distinguished history. In the second half of the 18th century the Swedish physician and botanist Karl von Linné, better known as Linnaeus, made experimental investigations on the effects of brandy which he regarded as the main cause of the ravages of drunkenness. He also induced a number of his medical students to investigate the effects of brandy and to write their doctoral theses on this matter.

In the eighteen-forties, the Swedish physician Magnus Huss, who coined the term "alcoholismus chronicus", produced the first elaborate clinical research on alcoholism, and in 1849 he published a book on this subject. (There were, of course, descriptions of various diseases incumbent upon alcoholism before his time, but they were not based upon what may be called clinical research). Huss also influenced the Swedish physiologist Dahlstrom to carry out the administration of pure "fusel oil" to animals in order to determine whether alcohol or fusel oil were responsible for the physical ravages of drunkenness. (The results were negative.)

In the first half of the present century Professors Widmark and Liljestrand gave a strong impetus to the research on the metabolism of alcohol, not only in Sweden, but in the pharmacological and physiological laboratories of Europe and America. In the past 15 years, Professor L. Goldberg[2] of the Karolinska University has carried out research on tolerance to alcohol, on "drunken driving" and on multiple addictions.

While physicians and psychiatrists have not been able to influence government action and public opinion until very recently, Sweden has taken notice of these researches and is justifiably proud of them. In view of these trends the 1954 Act on matters of "temperance," authorized the creation of a large government institute on alcoholism research, and the Karolinska University created the world's first chair of alcoholism research. Its first and present incumbent is Professor L. Goldberg.

The new research institute - with great laboratories and with a treatment unit which is to furnish research material - is at present in temporary buildings, but the construction of a new research building is near completion. This new institute is exemplary, not alone for its activities, but also for its architectural structure (Armstrong, 1959).[9]

Legal Controls

The most recent important amendment of the Swedish alcohol legislation came into effect on October 1, 1955. Before that time Sweden

had had, since the middle of the second decade of this century, a system of monopoly and individual control and rationing of spirit purchases - known as the Bratt system after its creator. The ration was one, two or three litres of spirituous liquors a month. Unitl 1941 the maximum allowance was four litres.

In 1955 rationing was abolished. The new system is not based to the same degree as previously on restrictive regulations concerning sales. It relies more on personal responsibility, as well as on scientific research on alcohol and its effect, on education and information, on support for recreational activities for youth and on more efficient care of alcoholics. Nevertheless the state still retains quite a strict control of the trade in alcohol itself.

With regard to the production and sale of alcoholic beverages certain basic principles are applied. These can be stated as follows. Swedish legislation distinguishes between the sale of strong drinks (spirituous liquors, wines and strong beer) and the sale of ordinary beer. There is a special legislation for the sale of strong drinks and a special legislation for the sale of beer. Ordinary beer may not contain more than 2.8 per cent of alcohol. Strong beer may contain not more than 4.5 per cent of alcohol but is sold under more stringent controls. Strong beer is available only in the retail depots of the state sales company and in restaurants which are licenced to serve such beverages.

Here it should be mentioned that the Swedish breweries also make a so-called light beer with an alcohol content of not more than 1.8 per cent. It competes successfully with the ordinary beer as a table beverage. This light beer is treated in the legislation on the same basis as non-alcoholic beverages. All sales of alcoholic beverages are to be handled in such a way that as little harm as possible results.

Another basic principle is that for the manufacture and sale of alcoholic beverages special permission from an authority is required. The production of spirituous liquors for a person's own use is prohibited. (On the other hand individuals are permitted to make wine and beer for household needs.) Moreover, the retailing of strong drinks may only take place in special shops which are managed by the state sales company.

The sale of strong drinks is concentrated in the hands of monopoly companies in which the state has the decisive influence. There is one such company for wholesale trade, Vin - och Spritcentralen, and another for retail trade, Nya System AB.

An important rule is that as far as possible the element of private profit should be removed from the selling of strong drinks. On the other

hand the profit element, as a rule, remains with regard to the production and sale of beer. For the serving of beer, however, there are certain so-called "public utility" companies which carry on their work without the aim of profit and which hand over any gains for purposes of public use.

The principle that selling may only take place if a special licence has been granted has been combined with a municipal local option. As a rule the elected council of the local authority has a decisive influence regarding the right to serve liquor. The county administration, which finally decides on these questions, cannot approve an application for a licence to serve liquor if the council of the local authority objects. On the other hand there are exceptions with regard to certain tourist hotels whose business is based on patrons from places other than that in which the hotel is situated.

Local option remains as regards the serving of liquor, but broadly speaking it has been abolished with regard to sales in the state shops retailing spirits. The local option, however, does not apply to temporary serving of liquor to closed groups. In this matter the superintendents of the Systembolag decide, and there is such a superintendent in each county. The county administration decides whether the right to serve alcohol in each particular case is to cover all kinds of strong drinks, only wine and strong beer, or only strong beer. Strong beer may not be served in ordinary beer restaurants.

It has already been mentioned that private profit has been dissociated from the manufacture and wholesale distribution of liquor and from the direct retailing to the public through the shops selling spirits. (Restaurants are not allowed to sell liquors for consumption off premises.) But the elimination of private profit extends also to the serving of spirituous liquors in restaurants. These restaurants are only allowed to receive a compensation estimated to equal their costs of serving spirituous liquors. This compensation consists of 15 per cent of the value of what is served, but there is a clause which stipulates that compensation will not be paid for sales of spirituous liquors above a certain level. The limit has been fixed on the basis that the quantity of spirituous liquors served should be in a resasonable proportion to the sales of food, non-alcoholic beverages and beer. The prices of spirituous liquors in restaurants are fixed by an authority called the Kontrollstyrelsen. For the serving of wines there is no limitation of profit, but the Kontrollstrelsen has to exercise a certain supervision over the pricing of wines. For strong beers the Kontrollstyrelsen fixes maximum prices.

Strictly speaking, it is only the waiters in restaurants who retain a direct private profit interest in the sales of spirits. Their interest is in the "tipping system" which provides that in restaurants serving spirits the tips shall be added to the patron's bill in the form of a certain per-

In Sweden there are five so-called public restaurant companies which are responsible for a large number of restaurants in different parts of the country and they are combined in a parent company known as the Swedish Central Restaurant Company. The shares in these companies are practically all owned by the state. The principle of the dissociation of the private profit interest from the serving of liquors is completely carried out and also applies to the business as a whole.

Since 1955 persons who have attained the age of 21 have, as a rule, the privilege to buy spirits, wine and strong beer in the shops of the state retail company in such quantities as they wish. These items may not, however, be sold to any person who is under the influence of alcoholic beverages. Moreover, strong drinks may not be sold to a person who abuses alcohol and who, by a decision of the appropriate county temperance board, may not purchase such liquors, to a person during the last year has been guilty of the unlawful selling of strong drinks; or if there is special reason to suspect an intention to make the items unlawfully available to another person. For each area the retail company draws up a "black list" of such persons and gives this to the members of the staff in the shops. In order that persons under the age of 21 shall not buy strong liquors in the shops customers must provide proof of their age and identity upon request.

Any one who gives alcoholic beverages to a person whom he knows to be an inmate of an institution for alcoholics or to a person who has been ordered by an institution or a temperance board to abstain from the use of alcohol is subject to heavy fines or imprisonment. The same applies to those who buy alcoholic beverages for a person who is under-age, or who is under the influence of alcohol.

Before 1955, restaurants were not permitted to serve spirituous liquors unless the customer at the same time took a meal. Moreover, there was a maximum quantity which the patron could be served, generally 15 centilitres. This rationing is now abolished in principle, but the owner of a restaurant is under obligation to see to it that a person who is visibly under the influence of alcohol or who is known to abuse alcohol shall not be served. "Reasonable requirements for sobriety and order-liness" at restaurants are also stipulated. Contravention of this rule is subject to punishment up to withdrawal of the license to serve alcoholic beverages. Strong drinks may not be served to persons who can be assumed not to have reached the age of 18. In principle there is still an obligation to take a meal at a restaurant serving spirits, but at present this has been experimentally suspended in large parts of the country unless the local authorities are opposed to such a step. Schnapps (brännvin), which is the type of spirit commonly consumed in Sweden and which is regarded as the greatest problem with regard to public sobriety, may still

be served in connection with a meal. After the experimental period is ended it will be decided whether the old rule to consume a meal with liquor shall be preserved in some form or entirely abolished. The law requires that restaurants which are licenced to serve alcoholic beverages shall also make available a satisfactory selection of non-alcoholic beverages. At present, efforts are being made on a voluntary basis to reach agreement with the restaurant owners on an extended service of non-alcoholic beverages. It is pointed out that it is in the restaurant owner's own interest to have a service suited to all categories of patrons.

Swedish legislation contains a number of restrictions which tend to ensure that young persons are not led to adopt drinking habits through the allure of entertainment offered by spirit-serving restaurants. Special permission is required for the sale of alcoholic drinks on occasions when dancing or other entertainment takes place in a restaurant, and the Local Council may refuse such permission, or grant it only under special safeguards.

The "Public Order Statute" forbids the sale and consumption of "strong liquor" at festivities or other gatherings open to the public and which take place indoors (or outdoors within an enclosed area). The law does not of course apply to such gatherings held at a restaurant or other place which is licensed to serve such beverages.

The abolition of the personal purchase book was based on the principle of "more freedom, more responsibility". In the first two years the reform act back-fired and there was an increase of over 30 per cent in the consumption of distilled spirits (6.04 litres distilled spirits per capita in 1954 and 7.88 litres in 1956). Beginning with 1957 the per capita consumption of spirits declined and by 1959 fell slightly below the level of the pre-reform year. There were upward trends in the per capita consumption of wines which by 1959 reached an increase of 58% (1.94 litres in 1954 and 3.07 litres in 1959). The consumption level of heavy and medium beer remained fairly stable, with an ultimate slight decrease, and the consumption of light beers went up. On the other hand the per 100,000 rate of convictions for drunkenness showed in 1959, an increase of 68 per cent, after having reached a top peak in 1957. The worst aspect is that in the age class of 15 years to 19 years there is an increase of 143 per cent of the per 100,000 rate. Whether this increase in the conviction rates for drunkenness may be ascribed to the abolition of the personal purchase books is difficult to assess at this time, particularly as it is not in step with the fact that total absolute alcohol consumption was 2 per cent below the 1954 level. Various examples of the early repercussions of the abolishment of the purchase book are given by Kälstrom (1959)[4]; Nilsson & Frey (1958)[5]; Elmer (1957)[6] and Lindgren (1957)[8].

It may be pointed out here that the drop in spirits consumption after the sharp rise in the first post-reform year cannot be ascribed to the awakening of responsibility of Swedish drinking population but rather to the repeated introduction of higher tax rates on distilled spirits.

One of the reasons for abandoning the Bratt system was that its supposed function to detect alcoholics failed. According to Elmer (1957) only 6 per cent of the persons with drinking problems who came to the notice of the temperance boards could be traced to data from the personal purchase books.

Sources:

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IV. NORWAY

At present the problem of alcoholism in Norway is considered as a medico-social one and the regulation of the sales of alcoholic beverages, as well as public care of alcoholics, is placed in the sphere of the Ministry of Social Affairs.

The general structure of the Norwegian governmental alcoholism program is similar to that of Sweden. There are, as in Sweden, Temperance Committees which may warn or supervise, or if necessary, commit excessive drinkers and alcoholics to treatment institutions; and there is monopolistic control of importation, production and sales of alcoholic beverages. There is also an educational effort either directed or subsidized by the government. Nevertheless, there are certain features in the program of Norway which merit special notice here.

Public Care of Alcoholics and Other Excessive Drinkers

The national government maintains state "sanatoria" for alcoholics and subsidizes six sanatoria founded and managed by voluntary philanthropic agencies. Apart from the treatment institutions, there have been established more recently a number of "supervision homes". Most of these "homes" are government institutions and some are operated by the Blue Cross. This latter type of facility for excessive drinkers and alcoholics has two main objectives:(a) to help excessive drinkers in the early stages of alcoholism, i.e., before they have lost control of their drinking, and, (b) to serve as half-way houses for alcoholics who are returning to the community after release from treatment institutions (sanatoria). In the supervision homes, the excessive drinker or alcoholic finds lodging and board and is not isolated from the community. He goes to work at a regular job and returns to the supervision home after work hours. The Health Insurance Agency pays 2/3 of the cost in these houses, while the remaining 1/3 is the obligation of the inmate. The stay in these "homes" is usually limited to two or three months. In contrast to the sanatoria which are always located in the countryside, quite a distance from cities, the supervision homes are established in the larger cities. Occasionally alcoholics committed to institutional treatment are sent for a brief period to a supervision home where they may await admission to a sanatorium whenever beds in the latter institution are not readily available.

There are also out-patient services for alcoholics, operated mostly by local Temperance Committees and by some voluntary organizations. Furthermore, alcoholics may be treated in general hospitals and in psychiatric nursing homes. It is of special interest that the Temperance Committees may advise, or if necessary, order the excessive drinker to undergo strictly medical treatment in a general hospital for a period

of 30 days. This period may be extended for another 30 days if proposed by a hospital physician. This procedure is made possible through a legislative act of 1957. A compulsory order for medical treatment in a general hospital is subject to the same procedures which Temperance Committees must observe in the commitment of an alcoholic to a treatment institution (sanatorium) for alcoholics, i.e., it requires that a judge should preside over the meeting of the Temperance Committee, that a medical opinion be sought and that the person in question may retain legal representation and have the right to appeal to a court. The act of 1957 also provides that Temperance Committees may extend their jurisdiction to the care of drug addicts. The latter are not numerous in Norway.

The emphasis on medical treatment is greater than in Sweden. Norway has a Chief Medical Officer for the supervision of the treatment of alcoholics. He is a psychiatrist and at the same time director of the State Institution for Alcoholics at Björnebekk, near Oslo. Apart from his work at the latter institution, he must supervise the other state sanatoria and advise their officials. Sometimes it is necessary for him to deal personally with certain patients in institutions which he visits. He also advises the Temperance Committees on medical questions and one of his most important functions is to determine to which sanatorium the patient should be admitted. This may include admission to a private sanatorium operated by a voluntary agency. All requests for admission of an alcoholic must be passed upon by the Chief Medical Officer. In making his decision, the officer considers the findings of the Temperance Committee as well as the wishes of the alcoholic in question.

It may be mentioned that the Temperance Committees may refer an alcoholic to Alcoholics Anonymous. The cooperation of official agencies with A.A. is rather well-developed. The Norwegian A.A., in contrast to the North American A.A. groups, and in agreement with the Danish A.A., attach considerable importance to medical treatment. As a matter of fact, they insist on medical treatment prior to joining A.A. They operate two nursing homes run by physicians. The larger one of the two A.A. nursing homes has five part-time physicians who treated 898 patients in the year 1957. The Health Insurance Agency covers, if necessary, the costs of treatment at the A.A. nursing homes for a period of 3 weeks and may extend this period on the advide of a physician. At these nursing homes, the patients receive all the medical and psychotherapeutic assistance which is deemed necessary. Patients may be given tranquillizers, but only in small amounts. Massive doses of vitamins are regarded as essential. Patients are informed about alcoholism as a sickness, and the physicians give lectures on the subject of alcoholism, and these lectures are followed by a question period. (That

alcoholism is an illness is written into Norwegian law.) Patients in these A.A. nursing homes take part once a week in A.A. group meetings at the nursing homes and they are required to keep in touch with one of the groups. The A.A. nursing homes receive a small government subsidy apart from the contributions of the Health Insurance Agency. This is quite a departure from the A.A. tradition in Canada and the U.S.A., where acceptance of financial aid from private and public sources is frowned upon. On the other hand, the Norwegian A.A. is much closer to the North American A.A. in its spiritual concepts than either the Swedish or Danish A.A. The Norwegian A.A. has now 86 groups with a total membership of roughly 7000 alcoholics.

It should be noted that the sanatoria (public and private) do not accept either aged alcoholics nor violent or dangerous alcoholics. The former are placed in institutions for the aged, and the latter are handled by the police, or if there are psychiatric involvements, by the mental hospitals.

Before going any further it should be mentioned at this point that in all matters of the local Temperance Committees and of public care of alcoholics, the State Temperance Council plays an advisory role. The important functions of this Council will be touched upon in two other sections of the present review.

In general it may be said that the institutional management of alcoholics is better than in Sweden and Finland, but not up to the standards of the Netherlands clinics nor to Canadian and U.S.A. provincial and state clinics. The treatment of alcoholics in psychiatric and general hospitals of Norway is well above the level of the state sanatoria in that country, but not of the high quality of the treatment in Swedish University hospitals and clinics.

Educational Activities

The official educational activities in Norway are largely entrusted to two bodies. The State (or National) Temperance Council carries out the education of the members of local Temperance Committees and particularly of persons appointed by the Temperance Committees to supervise alcoholics after their release from institutions. This aspect of education may be regarded as belonging to professional training, and is much concerned with instruction on the nature of alcoholism and the management of alcoholics.

The education of the general public on the effects of alcohol and the risks of abusing alcoholic beverages is in the hands of the National Board of Temperance Education which was created in 1902. The Board

includes representatives of the Social Ministry, the Ministry of Ecclesiastic and Educational Affairs, the Central Bureau of Statistics and the University of Oslo, as well as members of some private organizations concerned with alcoholism. The Board is strictly neutral with regard to the political aspects of the alcohol problem, such as "dry" policy, and they are independent of the total abstinence societies. This holds also for the State Temperance Council and the local Temperance Committees.

The National Board of Temperance Education concentrates largely on four activities:

(a) Lectures in schools and teachers' organizations.

(b) Courses for teachers and instructors on the problems of alcohol and organization of study by youth instructors.

(c) Production and distribution of films, posters, pamphlets and other media of instruction.

(d) The collection of literature on alcoholism and the maintenance of this collection in the Norwegian Temperance Library where it is available to the public.

The educational publications of the Board would not be viewed with favour by Canadian and U.S. educators in this field, although the Norwegian publications avoid making a moral issue of the simple use of alcoholic beverages. The posters and the tone of the pamphlets are not up to the high standards of Swiss temperance education.

The National Board receives a government subsidy which recently has reached 140,000 crowns (roughly $20,000) per year, but it has other sources of income, too.

Research Activities

There has not been any organized, systematic research on alcoholism in Norway, although private research workers in Norwegian hospitals and laboratories have produced some clinical investigations and physiological projects of fine workmanship. In this respect, Norway is far behind Sweden and Finland.

Recent legislation has led to the creation of an official alcoholism research institute in Oslo. This new institute, which was set up in 1959, is financed in its entirety by the State Goverment. It is an independent agency, but associated with the Norwegian Council for General Scientific Research. It will be primarily concerned with the sociological aspects

of the alcohol problem, but may support medical research in that field, mainly through study grants for laboratory work. The first studies of the new institute deal mainly with the follow-up of patients who have gone through the hands of the Temperance Committees.

Sales Controls

The Norwegian monopoly system is not too different from the Swedish one to warrant any detailed discussion. The importation and package sale is in the hands of a government company known as the A/S Vinmonopolet, which also controls the on-premises consumption of spirits by the glass. This latter form of sales is permitted in the six largest cities only. Package sale is permitted exclusively in towns with at least 4000 inhabitants. This does not mean that the state monopoly may open government stores in any such community. It can do so only where the municipality decides by vote that the sale of alcoholic beverages should be permitted. In other words, in spite of the state monopoly, there is local option in these matters. The price of alcoholic beverages is high in relation to disposable income.

The profits of the Monopoly go directly into the State Treasury. A part of the profits of the Monopoly is given over to social purposes, particularly to the campaign against tuberculosis. The law provides that 20 per cent of the license fees for the sale of spirits and 20 per cent of the profits of the Monopoly should be allocated to the Temperance Fund, whose purpose it is to foster temperance work. The largest part of this fund is applied to the support of sanatoria, including grants to the sanatoria operated by voluntary societies. The Temperance Fund has received in recent years 4,000,000 Crowns (approximately $560,000) per year.

In addition to this, the Norwegian Parliament has set up a state fund for alcohol-free hotels and hostels. The fund may be used for loans, initial outlay, extension and modernization of alcohol-free places of entertainment. The idea of fostering alcohol-free hotels and restaurants originated in Switzerland and is slowly finding its way into other countries.

The Integration of the Program

As has been seen, the total national program of Norway is constituted by many activities which belong to the sphere of various state agencies and societies, even though the management of excessive drinkers and alcoholics and the sales monopoly are under the Ministry of Social Affairs. There arise a number of questions of cooperation by other Ministries and departments and questions of staff development in the more than 700 local Temperance Committees.

A central organization known as the State (or National) Temperance Council was created in 1936. Its five members are appointed by the King. The chairman of this Council is usually an outstanding psychiatrist, and the other members too are persons with considerable knowledge of the problems of alcohol in their country. The Council is the link between the various branches of the Central Administration in legislative, administrative and medical matters. The Council advises the official institutions on problems created by alcoholism. The greatest task of the Council is to guide the Temperance Committees in their duties. The Council also supervises the distribution of subsidies which the State allocates for the fostering of information on alcoholism problems. It would seem that the Council does an effective job of coordination and it has done particularly well in the field of staff development. Although the Council was created in 1936, its full activities were only developed in the nineteen-fifties, as the war years under German occupation had practically disorganized their functioning.

The Act of 1957, with its provisions for the extension of medical work in the management of alcoholics, owes a great deal to the Council and is evidence of a trend toward more effective measures. Since the provisions of the 1957 legislation hardly came into effect before 1959, it would not do justice to their work, to evaluate it at this time.

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V. DENMARK

Herstedvester, An Example of the Treatment of Criminal Alcoholics

In the case of Denmark only the treatment of criminal alcoholics will be considered as that country has no legislation on the public care of alcoholics in general, nor does it have an alcoholic beverage production and sales monopoly such as is characteristic of other Nordic nations. There is, of course, some legislation on sales controls, but no measures which would be of unique nature.

On the other hand, there is in Denmark provision for the treatment of psychopathic, criminal alcoholics. The procedures in practice there constitute far better conditions for treatment within the structure of a prison than in any other country which has undertaken treatment of alcoholics in correctional institutions.

The Asylum for Psychopathic Criminals at Herstedvester (near Copenhagen) may be rightly designated as a prison hospital. It is a closed institution, but it has also one open section to which inmates may advance when indicated. This institution was created around 1940 through a legislative act which provides that all habitual psychopathic criminals (whether alcoholics or not) must be placed in special institutions with a therapeutic orientation in the strictest sense of the word. Punitive measures are avoided but not to the detriment of discipline. The inmates are under indefinite sentence and remain in the institution until they have shown "reasonable adjustment" and then they are placed on probation for two or more years. In the probationary period they are not only under supervision but treatment is continued to some extent.

Herstedvester is not a specialized institution for alcoholic criminals, but for psychopathic criminals in general. Nevertheless, the treatment of psychopathic, criminal alcoholics seems to be more intensive and more successful than that of other psychopathic criminals at that institution. This difference is evident from conversations with members of the psychiatric staff of Herstedvester as well as from published reports. It may be in order at this juncture to present some statistics relating to the above statement.

A survey of the criminal recidivism of non-alcoholic and alcoholic psychopathic criminals on parole was completed in 1951. The observation period of paroled prisoners averaged 20 months. Of the 118 non-alcoholic psychopathic parolees, 43, i.e., 36 per cent relapsed into criminal activities, and of the 40 alcoholic-psychopathic parolees, criminal recidivism occurred in that period among eight, i.e., 20 per cent. When

sex offenders are eliminated from the sample, the criminal recidivism for the 80 non-alcoholic parolees becomes 48 per cent, and for the 35 alcoholic parolees it remained at 20 per cent. Whether this outcome in favour of the alcoholic parolees may be ascribed to their more intensive treatment cannot be definitely stated but the assumption seems to be a reasonable one, particularly, since neither the incidence of psychopathies nor the past criminal record of the alcoholic parolees was of a lesser degree than of the non-alcoholic psychopathic parolees. The more intensive treatment of alcoholic criminals started in 1948 and is apparently still in effect.

The relatively good success with psychopathic criminals (alcoholics and non-alcoholics) may be attributed to the numerical adequacy of psychiatric-medical staff, psychologists and specialized social workers. The qualifications of the staff for this type of work are of a high degree. It may be noted that the professional staff make it a point to indoctrinate the penal staff of the institution into the objectives and ways and means for the rehabilitation of the inmates.

Without such a highly trained professional staff and a reasonable patient load per psychiatrist and social worker, the idea of treatment in a penal institution becomes illusory. A penal staff cannot be trained to become therapists -- at best they can be trained not to handicap the work of the therapists. This principle is all too frequently disregarded in many countries in setting up specialized penal institutions for psychopathic criminals in general, and for alcoholic criminals specifically. The Herstedvester example would indicate that a special institution for alcoholic criminals is not a necessary stipulation, but that they can be treated within the structure of an institution for psychopathic criminals in general. It is easier to find a high calibre professional staff for such an institution of wider interests than for an over-specialized penal institution for alcoholics, and furthermore the rehabilitation of criminal alcoholics is much more economical in the former than in the latter type of institution.

The Treatment

While Danish law makes it mandatory to place psychopathic criminals (non-alcoholic as well as alcoholic) in a special institution, treatment itself cannot be called compulsory in the strictest sense of the word. The alcoholic psychopathic criminal is not forced to subject himself to any specified treatment, nor even to direct contact with the physicians. These matters are left to the patient's decision. There is, however, an indirect therapy which the atmosphere of the institution offers, and after a certain period of defiance, practically all inmates express their wish for treatment.

Generally the inmates - with preference referred to as patients - have a wide choice in many matters such as the kind of work which they want to do in the institution. Their work activities are not determined by the needs of any workshop, e.g., the joiner's shop, printing works, etc., but by their own free choice. The same is the case in the use of their spare-time. It is the patient who decides whether or not he will take part in sports, entertainment, and even whether he will mix with others at all.

It is a general principle at Herstedvester to induce the patients to make decisions. This has its therapeutic value, although decisions are regarded at first as a great burden by those who in their previous experience in prisons were accustomed to letting rigid prison rules decide for them. On the other hand, there is no patient self-government.

Treatment is carried out by a team of four psychiatrists, two psychologists, four social workers, two nurses, one teacher, one personnel manager and three custodial officers. (Such a team is far superior to the treatment staff in any institution for non-criminal alcoholics in Sweden.) The team spends much time in consultation with each other, orienting themselves about the patients they much deal with. While in the institution everything concerning the patient's relation with the outside world, with his family and with non-legal authorities, is looked after by a social worker.

It is the experience at Herstedvester that the alcoholic patient encounters particular defficulties in resocialization and great efforts are made to gain knowledge of the factors in his personality which may have played a role in the development of his alcoholism. Such knowledge is applied in supportive psychotherapy of the patient in question.

Group discussions are being used more intensively at present than were before 1954. Participation in group therapy is not carried out by "order", but only if the patient expresses the desire to participate.

Disulfiram medication (Antabuse in this case) is started one or two months prior to the patient's release on parole. The reason for starting the medication so long before the patient is exposed to the possibility of drinking is to ensure that side effects of the drug will wear off before the patient is released. The appearance of side effects in the parole period could "justify" discontinuation of the medication.

Out-patient Treatment Under Parole Conditions

At this point, it must be mentioned that during the institutional period the patients receive weekly wages. Half of the wages they may

dispose of themselves and the other half is set aside for use after release on parole. A part of the savings is used to pay back taxes, outstanding union fees, court-ordered support payments and other such obligations, in order not to be faced with demands on the part of the public authorities when the parolee begins to work at a regular job. Furthermore, with the cooperation of the social worker, the parolee purchases out of savings, street-clothes and working-clothes. Thus he does not feel beholden to the institution for his new outfit. Lodging is also procured for him if he is single. In this connection it may be mentioned that the staff of the institution have felt the lack of Half-way Houses for the parolees.

While on parole the patients are still subject to treatment. Over a period of several weeks the social worker makes unannounced calls, and sometimes performs an alcohol reaction test. Initially the psychiatrists' work was limited to contacts within the institution and the social worker carried out the field work.

> "This procedure, however, soon proved to be insufficient. The logical sequence of examination, diagnosis and treatment, customary in general medical practice, cannot be strictly observed where alcoholics are concerned. With alcoholics all three components are protracted and concurrent. Constant attention must be focused on newly emerging factors; that is, the examination must be continual, new conclusions must be drawn from changes in or additions to the diagnosis, and the treatment must be adjusted to new findings. More than in any other medical field, elasticity and regard for the individual are necessary. It is consequently important - in some cases even essential - that the psychiatrist's work be not limited to the institutional period and then only to the supervision of the social worker's duties. The psychiatrist must cooperate intensively with the social worker - whose work is not lessened by this - and take part in the outpatient treatment. He now has a direct, personal contact with the patient's milieu and can assist particularly in cases where conflicts of a special kind may appear or have already appeared." (Hansen, H.A., and Teilmann, K., 1954).[1]

In the first weeks of parole, the patient is routinely visited by the social worker twice a week; and even more important are visits on account

of known or suspected difficulties. Much of this work is carried out in the evening and even during the night.

The disulfiram treatment poses the problem of finding someone who will support the patient in his daily use of the drug. As the wife is in an awkward position if she has to act as supervisor. arrangements are made to have a foreman and sometimes the employer, administering the drug.

Members of the professional staff of the institution have expressed the opinion that the disulfiram therapy has rarely been followed by parolees for any length of time. Nevertheless, the staff feel that this treatment has some value, particularly as it has brought home to patients the idea that their alcoholism is a disease.

According to a conversation which I had in the Spring of 1961 with Dr. George Sturup, Director of the Herstedvester Asylum, the procedures for the treatment of psychopathic alcoholic criminals is at present essentially unchanged and no newer publications on this subject have appeared.

- Other Aspects of Activities Relating to Alcoholism -

Voluntary Societies for the Care of Alcoholics

There is no compulsory treatment of alcoholics in Denmark except for psychopathic criminal alcoholics; and even in this instance only commitment to Herstedvester is compulsory, treatment being a matter of choice by the inmates. (There is a provision in the regulations of the Danish National Health Board which requires physicians to furnish, apart from reports on infectious diseases, an annual report to the Public Health Officer regarding "conditions which, in the opinion of the physician, are deserving mention". Whether or not this provision includes alcoholism is not clear). Nor can one speak of public care of alcoholics in Denmark as there are no government operated or subsidized clinics for alcoholics, except for municipal facilities in Copenhagen. The Municipal Clinic for alcoholics is geared to out-patient treatment; there is a small in-patient unit (Overforstergaarden) which is affiliated and staffed by the Municipal Clinic. The emphasis is on social rehabilitation. There is also a Police Social Work Clinic which is related to the Forensic Institute of the Copenhagen Police Department. This latter Institute played a considerable role in popularizing disulfiram treatment in Denmark.

The Social-Psychiatric Department of the municipality of Århus takes some interest in alcoholism, but could hardly be considered as a treatment facility for alcoholics.

In spite of the absence of public care of alcoholics, it may be said that voluntary associations for the care of alcoholics provide adequate facilities for their treatment. Foremost among these voluntary associations is the Alcohol Therapeutic Society which is constituted by a membership of approximately 50 physicians and the Ring i Ring (the Danish version of Alcoholics Anonymous). These two associations work in the closest co-operation. In contrast to the A.A. groups on the North American continent, the Danish A.A. places strong emphasis on medical treatment, generally accepts disulfiram treatment and psychotherapy by psychiatrists, but the spiritual element is kept in the background. Public confession is by no means the routine of the Danish A.A., who concentrate rather on lectures and discussions. The Ring i Ring in co-operation with the Alcohol Therapeutic Society takes care of between 400 and 500 new alcoholics per year.

There are three Blue Cross sanatoria which admit approximately 160 new patients per year. It is of interest that the Danish total abstinence societies operate 25 "dispensaries" which care for close to 800 new alcoholic patients per year. Whether the procedures in these dispensaries amount to treatment cannot be said.

Generally, for such a small country as Denmark, the voluntary facilities provided for alcoholics seem to be sufficient, particularly in view of the fact that psychopathic, criminal alcoholics are treated in a government institution. It goes without saying that the Danish mental hospitals take care of alcoholics with psychoses. The latter constitute approximately 8 per cent of the total psychotic admissions.

Sales Controls

As mentioned before, Denmark has neither production nor sales monopoly of alcoholic beverages. Control regulations are generally of little interest, except for one feature which sets a high differential tax rate on distilled beverages. This increase in the tax rate brought about a considerable drop in distilled spirit consumption and an increase in beer consumption. It must be said, however, that at the introduction of the high tax-differential Denmark was already predominantly a beer drinking country, and that the distilled spirit consumption was far below the level at which it was in the first two decades of the present century. Furthermore, while the high taxation diminished spirit consumption even more in the first few years of the new tax policies, there was an upward tendency in spirit consumption when inflation became more pronounced and all commodities increased in price, while at the same time, disposable income increased too.

Sources:

1) Hansen, H.A. and Teilmann, K. Quart. J. Stud. Alc. 15: 246, 1954.

2) The Herstedvester Papers, 1958. Armstrong, J. Clinical Notes Re European Visit, 1959 (Mimeographed).

3) Oral and Written Communications from Dr. Alf Yde; Dr. George Sturup; Dr. M. Schmidt; Dr. Eric Jacobsen and Mr. S. Rügind.

VI. SWITZERLAND

Prevention of Alcoholism, Care and Treatment of Alcoholics and Legal Control Measures

Financial Aid and Advisory Service of the Federal Government

While the federal government has no specific legislation on the care of alcoholics and the prevention of alcoholism there are certain dispositions in various federal enactments which contribute to a considerable extent to the achievement of these goals.

The most important pieces of legislation in this respect are the revision of the alcohol paragraph of the Federal Constitution in 1930 and the Alcohol Law of 1932 based upon that revision. This superseded the earlier revision of the constitution of 1885 and the alcohol laws of 1886, 1900 and 1910 (see Steiger, 1953)[2]. Certain financial provisions, enabled by the revision of the constitution and elaborated in the Alcohol Laws, are discussed in the present section, while other important dispositions are discussed under the heading, Legal Control Measures.

A significant decree of 1954 concerns the creation of a federal advisory body, known as the Commission Fèdèrale contre l'Alcoolisme.

There are, furthermore, certain articles in the Swiss Civil Code, the Swiss Penal Code, the law of 1911 on health and accident insurance, and some other federal legislation which form the legal basis of cantonal legislation on the commitment and care of alcoholics.

The Federal Subsidies

The above mentioned legislation of 1930 and 1932 contains modern versions of constitutional dispositions and acts dating back to 1885. These older acts determined that half of the surplus resulting from the transactions of the Federal Alcohol Administration should be distributed to the cantons (in proportion to their populations) and that one tenth of such funds must be used by the cantons for prevention and curative activities relating to alcoholism. The older versions of the "alcohol tenth" were concerned more with the effects of alcohol than with the causes of alcoholism (Kurt).

This disposition has made it possible to develop prevention and care beyond the limits of private and cantonal means.

At present the surplus of the Alcohol Administration amounts to roughly $8,000,000, of which half goes to the cantons. The "alcohol tenth" thus amounts to approximately $400,000, but the cantons actually spend more than this amount on matters concerning alcoholism.

The scope of the alcoholism tenth comprises the following items:

(1) Support of Campaign against alcoholism.
(2) Public education on nutrition and the dangers of alcoholism.
(3) Encouragement of the use of alcohol free beverages.
(4) Aid to alcoholics discharged from institutions.
(5) Expenses for destitute travellers in alcohol free hostels.
(6) Upkeep of Welfare Bureaux for alcoholics (dispensaries), commitment to institutions for alcoholics, and hospitalization.
(7) Contributions to private institutions admitting alcoholics.
(8) Placement and care of children neglected because of alcoholism in the family.

About half of the alcohol tenth is spent on treatment of alcoholics. It is also noteworthy that of the "alcohol tenth" which comes from the Alcohol Administration, nearly 1/3 is spent on frankly "anti-alcoholic" purposes (items 1, 2, 3, and 5). This gives evidence of the government's intention to decrease the alcoholic beverage consumption. This tendency will be seen again in reports of some other activities of the Alcohol Administration.

The Federal Consultative Service

The Commission Fédérale contre l'Alcoolisme was created by federal decree of 1945 as a consultative body. Its membership consists of prominent physicians, judges, legislators, administrators of government agencies as well as representatives of temperance societies. The Commission also has a small permanent staff. The objects of the Commission are to advise (on request) cantonal governments on matters of public care and treatment of alcoholics, to foster research (as well as to carry out studies of its own) which may serve as materials in its advisory functions and to subsidize publications on alcoholism. In all these fields the Commission has performed valuable services.

One example of their activities was the way they took the initiative in showing health insurance authorities that it was in their own interest to contribute towards the costs of the rehabilitation of alcoholics. They also were responsible for an important survey of the question whether and, if so, under which conditions, alcoholism may be regarded as an illness (Commission Fédérale contre l'Alcoolisme, 1951).

The Temperance Movement

The activities of temperance societies have been, and still are, a prominent factor in the prevention of alcoholism in Switzerland, and must be considered here in some detail.

There was no lack of warnings against excessive drinking habits before the nineteenth century in Switzerland. Even the great Bernese physiologist Albrecht von Haller (1708 - 1777) went so far as to say that the custom of drinking is best combatted by not following it, but there was no total abstinence movement in Switzerland before 1877.

Moderation societies which demanded abstinence from distilled spirits, but approved of the moderate use of beer and wine were founded in Switzerland as early as 1830.

Distilled spirits were not regarded as a necessity and it did not seem too bold a step to reject them entirely. On the other hand, wine was so much a part of the Swiss way of living that no one would have thought of demanding more than moderation in the use of wine and beer. The idea of abstinence from all alcoholic beverages did not occur even to the famous fighter against drunkeness, L. L. Rochat (1843-1917) until he made a visit to England, where he got acquainted with English temperance workers. He "found to his great surprise that one could live without wine or beer" (Oettle).

In 1877 Rochat founded the "Blue Cross", the first temperance society which demanded total abstinence from its members, and the first which was not just of transitory duration. Many other temperance societies which embraced the idea of total abstinence followed. The Blue Cross and other societies from their very beginning were concerned with salvaging the inebriate, a task which started rather slowly. This objective however, gained momentum after the Fürsorger, the specialized councillors of alcoholics, grew out of the temperance movement and constituted a profession. Except for the Blue Cross Fürsorger they do not as a rule represent temperance societies although they may be members. There are various philanthropic organizations which have created Fürsorger bureaux.

Despite the fact that the Swiss temperance movement has as its objective the propagandization of voluntary total abstinence, it refrains from representing total abstinence as a moral obligation of every person and implying that any use of alcoholic beverages is immoral. The late Professor von Bunge of Berne University expressed the latter view in 1886 and his attitude caused wide indignation. Impressive support of the temperance movement came from two famed Swiss psychiatrists, August Forel and Eugen Bleuler.

The Swiss temperance societies have succeeded in not arousing too much antagonism and have won the somewhat grudging respect of the public. This fact is reflected not only in the courtesy which the Swiss Government extends to these societies but also in financial subsidies granted to them either directly or indirectly, through the cantonal governments. The general feeling of the public is that the use of alcoholic beverages is everybody's private affair but that drunkeness is a matter which comes legitimately into the field of temperance societies.

Not counting the youth organizations, there are 20 temperance societies and numerous local associations. Most prominent are the Blue Cross with over 22,000 members and the Order of Good Templars. The Secretariat Antialcoolique Suisse, in Lausanne, is in a way a clearing house of the Swiss temperance movement.

The Blue Cross and some other temperance societies are denominational, but there are a number of non-denominational as well as politically neutral organizations. Of particular interest is the formation of some temperance societies by occupational groups. Among these are abstinence societies of teachers (with 1200 members), railroad men (with over 1500 members), and physicians (with 100 members). There are also abstinence societies formed by members of sports clubs, such as bicycle riders and motorists, gymnasts and alpinists. Various temperance organizations of children and youths total around 25,000 members.

Since the Second World War the Swiss temperance societies have not seen an increase but rather a decline in membership. Their role in civic life, however, has not diminished.

The work of these societies has been constructive in many ways. Their fostering of unfermented fruit juices is, of course, to some extent motivated by the wish to give people a substitute for alcoholic beverages, but its main objective is to give the viticulturists and orchard growers a means to utilize their produce for other purposes than fermentation and thus ease the pressure on the sale of alcoholic beverages.

An important aspect of the Swiss temperance movement is its cooperation with certain benovolent societies in the creation of alcohol-free restaurants which number close to 600, and the encouragement of more than 150 alcohol-free hotels and boarding houses, not to speak of hundreds of alcohol-free tea-rooms and coffee houses. The total of all alcohol-free premises is placed at 1800. The fact that there are places where one may eat without covert pressure toward the use of wine or beer does have some effect on the reduction of alcohol consumption. The alcohol-free restaurants are generally attractive places with good food service, and many of their clients are not total abstainers. In this connection it may also be mentioned that there are alcohol-free vacation facilities and youth hostels.

The Swiss temperance almanac lists 21 German-language periodicals, seven French journals and one Italian journal, devoted to the temperance cause. Some of these periodicals, especially the "Sauvegarde" and the "Fürsorger", carry information of interest to the scientific student of alcoholism.

The various temperance groups have issued a great mass of pamphlets some of which represent a good educational effort, but most of which do not find readers outside of the temperance circles. On the other hand, the Swiss temperance posters, particularly those issued by the Sécretariat Antialcoolique Suisse, cannot be easily ignored. The posters with their attractive and excellently reproduced pictures compel attention, and the brief texts accompanying the pictures are to the point and give rise to thought rather than to antagonistic emotions.

In matters of control legislation, the Swiss temperance societies may have had some indirect influence. Some of the measures advocated by them are perhaps more a matter of reasoning from traditional assumptions than of deep penetration into the problems of alcohol. They have also stimulated the public care of alcoholics and have adopted and propagated the conception of alcoholism as an illness. Whether the nature of the "illness" has been understood is not quite evident from the ideas on its treatment.

The Public Care and Commitment of Various Categories of Alcoholics

Matters relating to the public care of alcoholics in Switzerland are left to the legislative action of cantons. Consequently, it is difficult to speak of this question in Switzerland as a whole. The question would have to be examined canton by canton. Nevertheless, there are in the cantonal legislative acts on the care of alcoholics some common elements which are due to the fact that such legislation is derived from certain dispositions of the federal civil code, the federal penal code and some other federal legislative acts.

Aside from the fact that some federal legislation facilitates cantonal legislation on the public care of alcoholics, the federal government plays a role in this matter through financial contributions derived from the revenue of the Federal Alcohol Administration and through certain services of the Federal Commission against Alcoholism.

Three aspects of the public care of alcoholics must be distinguished in Switzerland, namely, the commitment of alcoholics with mental disorders to a mental hospital, the commitment of certain criminal alcoholics to treatment centres and the care and possible commitment of all other alcoholics who do not suffer from mental disorders nor

come into the category of criminals under court sentence although they may have served a sentence in the past.

It is not necessary to go into a discussion of the commitment of alcoholics with mental disorders except to say that the Swiss mental hospitals are conducted in conformity with the great reputation of Swiss psychiatry and that the treatment of alcoholics with mental disorders is generally of a high quality.

The Care of Alcoholics in General

Under the above heading are considered only those alcoholics who do not suffer from mental disorders and are not under sentence for some crime or offence.

Generally the care and treatment of alcoholics was initiated in Switzerland by temperance societies. By and large this function of the temperance societies still prevails directly or indirectly through the role of the welfare workers, the Fürsorger.

The consultation bureaux of the welfare workers (Fürsorgestelle, dispensaire antialcoolique) are utilized and subsidized by the cantons irrespective of whether or not they have legislation on the care and commitment of alcoholics.

It is difficult to translate the word Fürsorger into English, at least in the sense in which this term is used in Switzerland. In the case of German and especially Austrian Fürsorger, however, an English equivalent is more readily established. The Swiss Fürsorger for alcoholics are not social workers in the Anglo-American sense, and their designation as welfare workers also does not quite cover the functions envisaged under that heading. They shall be referred to here nevertheless as welfare workers. A few words about the welfare workers seems to be indicated in view of their importance in the care of alcoholics in Switzerland.

These Fürsorger were originally members of temperance societies who volunteered to help alcoholics to rid themselves of their alcoholic habits; to counsel with their families and to mediate for them material assistance and to help in obtaining employment. Later, aside from volunteers, the temperance societies engaged Fürsorger in full time or part-time capacities.

The Fürsorger for the counselling of alcoholics began to have meetings for the exchange of ideas on the work with inebriates. In 1926 they constituted an association under the name Verband Schweizerischer Trinker-Fürsorger which admitted as members persons who carried out welfare work with alcoholics principally or as a part-time

vocation, namely, Fürsorger of recognized consultation bureaux for alcoholics, the heads of special treatment institutions for alcoholics (Trinkerheilstätten) and other professional Fürsorger.

The Fürsorger for alcoholics, irrespective of whether or not they are employed by a temperance society, are, with very few exceptions, total abstainers. The abstention from alcoholic beverages is regarded as an essential condition for the work with alcoholics among the Fürsorger of Switzerland as well as in Germany. This stipulation may seem strange to therapists in many countries. It seems, however, that in Switzerland this custom is in keeping with the character of the majority of alcoholics, although in a minority it may be a deterrant factor in accepting help.

Generally, the Fürsorger have no specialized training in social or welfare work, but scientific courses on alcoholism have been conducted for them more or less regularly for several years. More recently a special training centre has been established.

Some of the consultation bureaux are denominational, but largely they are denominationally and politically neutral. Nevertheless the Fürsorger are of a religious temperament or, let us say, they have a spiritual outlook which plays a role in their work with alcoholics. It may be said that the Fürsorger are men of high principles and deeply devoted to their work, and while they may lack specialized training there are some of high educational standards.

Corporatively the Fürsorger have exercised a salutary influence on legislation concerning the public care of alcoholics and the prevention of alcoholism. They have emphasized that measures which do not recognize the necessity for the social and personal adjustment of alcoholics are not particularly useful.

In the discussion of the main principles of cantonal legislation on the care and commitment of alcoholics it will be seen how important the functions of the Fürsorger are in Switzerland.

The Main Basis of Cantonal Legislation for the Public Care of Alcoholics

Legislation on the care and commitment of alcoholics exist in the following seventeen cantons: Graubünden, St. Gallen, Zürich, Schaffhausen, Fribourg, Luzern, Baselstadt, Baselland, Aargau, Zug, Vaud Neuchatel, Genève, Tessin, Solothurn, Thurgau and Appenzell A.-Rh.

By and large cantonal legislation on these matters takes recourse to certain articles of the Swiss civil code relating to "guardianship".

The provisions of guardianship cover persons with mental disorders and mental deficiencies (art. 369), and those persons who through profligacy, drunkeness, dissolute conduct or their financial bearing expose themselves or their families to pauperism and those who need continuous aid and care or endanger the safety of others (art. 370). Drunkeness par se, (i.e., without the qualifications mentioned in art. 370) does not constitute grounds for guardianship, and thus does not cover incipient alcoholics. On the other hand some cantonal legislation takes into consideration drinkers who show signs of the onset of "alcohol addiction", (e.g., Canton of Solothurn).

A person may not be placed under guardianship without being granted a hearing (art. 374). The authorities for guardianship and the modus of implementation are determined by the cantons (art. 372).

The idea of guardianship is ethically acceptable as it implies the helplessness and need of protection of the alcoholic. The principle is the more acceptable as nearly most cantonal laws on the care and commitment of alcoholics either explicitly or implicitly try to avoid guardianship through warnings and more importantly through referral to the Fürsorge bureaux. Furthermore, the declaration of guardianship is surrounded by so many safeguards that it cannot be wantonly applied through the wish of family members or others who may feel inconvenienced by the alcoholic.

The possibility of guardianship is quite a deterrent for many alcoholics, especially those who are more physically than psychologically dependent upon alcohol. It induces them to accept more readily the help of the Fürsorge, or even voluntary commitment to an institution for the rehabilitation of alcoholics.

Rusterholz (1939)[5] points out that useful legislation on the care of alcoholics should provide the possibility of obligatory commitment for treatment without necessarily placing the patient first under guardianship. Tutelage is such an incisive measure that one hesitates to invoke it except in extreme instances, when it is usually too late for successful treatment.

Luzi (1950)[4] says that most of the cantonal legislation on the care of alcoholics is essentially a supplementation of the existing private welfare activities. He implies that legislation should tend to place the entire activities in this field into the hands of the cantonal public authorities, as is the case in Graubünden and Vaud. Nevertheless, the public Fürsorge bureau is not necessarily the ideal goal of legislation. The supplementation of private welfare through legislative acts, is in some cantons rather far reaching, and can result in efficient procedures, as for instance in the Canton of St. Gallen. However, it would seem,

desirable that public measures pertaining to the care of alcoholics should make provision for more medical care than is the case at present, and that the subsidy of private welfare activities through public funds should be made subject to the observation of some weil defined standards.

It is not possible in this study to give details of the pertinent legislation of each of the 17 cantons which have provisions for the care of alcoholics. But some of the main measures are, in their broad principles, common to many cantons which provide for the public care of alcoholics.

Generally the first step may be a warning by some official authority. In some cantons strict measures may be taken without a previous warning.

When the warning has no effect the public guardian's office may place the person in question on probation for a certain period, and for the duration of probation he may be instructed to abstain from alcoholic beverages and to join a temperance society or to seek treatment for his alcoholism.

If during the probationary period no improvement is noted, the alcoholic may be committed to an institution for the rehabilitation of alcoholics (Trinkerheilstätte). This requires a medical opinion, as well as a hearing of the person in question. Furthermore, the suspected alcoholic may be referred to a hospital for observation and expert opinion.

After discharge from such an institution the visiting of drinking places may be forbidden for a period up to two years. For anyone thus prohibited from visiting drinking places some cantons assign a "protector", who, however, does not have the functions and powers of a guardian. The "protectorship" can be assigned to public or private welfare Fürsorge bureaux for alcoholics.

On the other hand, when tutelage becomes necessary, it is a principle that care and guardianship should not be vested in the same person.

While there is a growing tendency towards a true therapeutic outlook, much of the cantonal legislation has a penological orientation. This is particularly strange in a country which has quite a number of psychiatrists who have a deep understanding of the problem, and have made valuable contributions towards the world literature on alcoholism. Apparently they have not sufficient influence on public opinion. If in spite of outdated laws, the penological attitude is greatly mitigated in practice, the credit goes largely to the humanitarian welfare workers for alcoholism.

Most of the work with alcoholics is carried out extramurally by the various Fürsorge bureaux. In view of the large number of alcoholics, however, the number of full-time Fürsorger is too small to permit intensive counselling work.

A fairly common feature of cantonal legislations is that a given public authority proposes certain measures concerning a known alcoholic, but that the decision rests with another authority. Generally, not too many functions are vested in the same authority and this principle, while it may prolong procedures, is a safeguard against arbitrary decisions.

There is considerable variation from canton to canton as to the authorities principally in charge of referral, commitment and supervision of alcoholics. The main authority may be the Municipal Council of the place of residence of the alcoholic; a specialized agency - the cantonal public health service - the authority for the care of paupers; the public guardians office, and so forth. Of course the effectiveness of such measures depends to some extent on the nature of the executive agency. Without prejudice to the efficient work of various agencies, a public health authority would seem to be the most appropriate organ for the administration of laws on the public care of alcoholics.

It is frequently said that the Fürsorger have a negative attitude towards the medical treatment of alcoholics. Such a statement must be taken with due caution. At the time when aversion treatment, curethyl, disulfiram (e.g. antabuse) and other drug treatments of alcoholics were introduced, there was in certain circles a tendency to rely on these drugs to the exclusion of social and psychological treatment factors. Such an attitude aroused the suspicion of the Fürsorger toward the drug treatments as their experience had taught them that the alcoholic has problems which cannot be eliminated through injections and tablets. They may have gone too far in their rejection of drug treatments and may have extended in some instances their negative attitude to any medical treatment of alcoholics. Generally, however, it seems that they admit the need for the treatment of withdrawal symptoms and processes covered by the term detoxication. Nevertheless, it seems that too few alcoholics under the care of Fürsorger receive medical treatment of the physical disturbances caused by chronic alcoholic intoxication. This point has been made also by Bersot (1944). The stresses and strains induced by chronic intoxication, if not relieved, frequently lead back to the use of alcohol, a fact which has not received sufficient consideration.

Commitment of Criminal Alcoholics

As to the commitment of criminal alcoholics, provisions emanate from Art. 44 of the Swiss Criminal Code. In the course of years this article has undergone many changes and here only its present form shall be considered.

Art. 44 came into effect through a national referendum of July 3, 1938. This article limits the possibility of commitment to an institution for alcoholics (Trinkerheilstalt) to those "habitual drinkers" who, on account of some infraction of the law, have been sentenced to jail.

On the other hand, those committed to prison must take their punishment in full. Furthermore, the court cannot commit to institutions for alcoholics those "habitual drinkers" who have been acquitted because of a condition which excludes criminal responsibility.

Court commitment to a specialized "institution of cure" presupposes that the persons sentenced to jail or detention are "habitual drinkers" and that their delinquencies are related to their drinking. Thus, only those delinquents come into consideration whose inebriety has developed into an irresistible tendency.

According to the wording of Article 44, para. 1, it would appear that those who are primarily criminals and only secondarily inebriates, do not come under the provisions for court commitment to "institutions of cure" as their delinquencies cannot be regarded as resulting from their drinking habits. Such at least is the interpretation given by Frick (1950).

Since Article 44 provides that only those who have been sentenced to jail or detention can be committed by the judge to "institutions of cure," it follows that commitment by the judge to "institutions of cure" cannot be extended to those who have been acquitted as criminally not responsible persons.

On the other hand, Article 263 of the Swiss penal code provides that persons who become criminally irresponsible through self-inflicted drunkeness and thus commit an infraction of the law, may be sentenced to jail up to six months or to fines. In this case, a commitment by the judge to an "institution of cure" is possible.

The Swiss Penal Code (Article 382) requires from the cantons that they provide for the above-mentioned court commitments, institutions for the treatment of alcoholics. The cantons are permitted to make agreements in this matter with other cantons and furthermore, they are permitted to make use of private "institutions of cure".

Mohr (1943) observes that the treatment of criminal alcoholics is the same as of alcoholics in general, and that, in a way, the court sentence is a safeguard against early dismissal. On the other hand he feels that the treatment of criminal alcoholics is more difficult, as their criminality is evidence of considerable deterioration.

Institutions for Alcoholics

Three broad categories of the above institutions may be distinguished: (a) specialized separate institutions, known as "Institutions of Cure for Alcoholic Patients"; (b) branch departments of either penal institutions or work houses, or mental hospitals; and (c) "homes for alcoholics" (Heimstätten).

The official List of the Swiss Association of Welfare Workers for Alcoholics enumerates nine "Institutions of Cure" (three of these for women) with a total of 275 beds. These institutions were founded by philanthropic and religious societies and continue to be managed by them. Through contracts with cantonal governments and subsidies indirectly derived from federal funds, these institutions have a semi-public character.

The "Institutions of Cure" are managed by lay therapists. Only three of these institutions have a consultative medical service for the treatment of alcoholism, while the others limit medical service to instances of illnesses.

Thus, these institutions are neither hospitals nor clinics. Consequently, the health insurance agencies are legally not required to contribute towards the costs of the treatment of the alcoholic behaviour, although they are required to cover the costs of treatment of illnesses caused by alcoholism. Nevertheless, a few of the larger health insurance agencies voluntarily contribute towards the costs of treatment in an "Institution of Cure".

The basic element of treatment in the "Institutions of Cure", are total abstinence work, therapy, a wholesome way of living, and readjustment to the difficulties of life.

The alcoholic departments of penal and mental institutions separate the alcoholics physically from the other inmates or patients, but they are not specialized institutions. They are closed wards and conform entirely with the character and discipline of the mother institution. In this sense, according to Frick (1950), these departments cannot be regarded as specialized state institutions for alcoholics, nor are they particularly suitable for the treatment of such patients. There are five such departments with 254 beds enumerated in the above mentioned "List" of 1954.

The "homes for alcoholics" are for "incurable alcoholics" or alcoholics who are presumably "difficult to treat". These "homes" are largely custodial institutions. The "List" mentions only one with 10 beds.

The inadequacy of the institutional treatment in Switzerland has also been pointed out by Heinziker (1958) who is by training a lawyer and who is primarily interested in the legal aspects of the problem. He has a good insight into the institutional treatment of alcoholics in his country.

Legislative Measures Contributing Toward the Control of Alcoholic Excess

The laws concerning "habitual drunkards" and addictive drinkers belong under the heading of control measures. However, as this specific aspect of control measures has been discussed under the heading of public care of alcoholics, it need not be again considered here. Furthermore, the discussion of public care laws has sufficiently pointed up the Swiss legal view on drunkeness and criminal responsibility.

It remains for this section to deal with laws and measures concerning the limitation of production and sale and, consequently, the indirect limitation of consumption of alcoholic beverages. In addition the measures relating to alcohol and highway traffic come under the present heading.

Two important control laws will be considered here. One concerns the regulation of taverns, restaurants, cafés, inns and hotels and other guesthouses. For brevity's sake this will be referred to as the "public-house" law (in the German terminology of Switzerland it is known as the Wirtschaftsgesetzgebung). The other law concerns the "alcohol monopoly" (Alkoholgesetzgebung).

The "Alcohol Monopoly"

In order to avoid any possible misunderstanding, it must be stated here that "alcohol monopoly" refers only to distilled spirits and not to fermented alcoholic beverages. Furthermore, in the instance of Switzerland "Monopoly" is a much more limited system than, for instance, in Sweden, Norway and Finland, i.e., Switzerland has "monopoly stores" for the sale of bottled spirits.

At the same time when wide-spread opinions pressed for a revision of the laws governing "public-houses", a demand was voiced for a reform in matters relating to the production of distilled spirits. The latter demand arose from the fact that the production of distilled spirits from potatoes was threatening to flood the country.

As in the case of "public-house-reform" a revision of the pertinent dispositions of the federal constitution was prerequisite for a regulation of the production and sale of distilled spirits. The constitutional amendments of 1895 and the corresponding legislative acts of 1896 on the above

matters constitute twin legislation. But while the regulation of "public-houses" was left to the cantons on the basis of some directives, the alcohol act of 1885 placed the matter of distilled spirits into the hands of the federal government, in the form of a monopoly. A Federal Administration was created to carry out all transactions of the monopoly. For detailed discussions of the laws concerning the monopoly and its activities reference may be made to Steiger (1946 and 1953)[1], Kühne (1950) and Kellerhale (1955).

The aim of the Alcohol Act of 1885 was to render potato spirits so expensive that the price differential would channel the consumption from distilled spirits to the fermented beverages of much lower alcohol content. As all spirits distilled from potatoes had to be delivered to the Alcohol Administration, which became the sole seller of that commodity, the aims of the price policy were achieved and a sharp drop in distilled spirits consumption was seen. This lower consumption level was maintained for a considerable period but later, owing to a loophole in the law, the aims of the Alcohol Administration were threatened with frustration.

The federal constitution had exempted from federal control and taxation the distillation of wine, grape marcs and from fruit ciders as these seemed to constitute an unimportant source of brandies in comparison with the large scale potato distillation. The high price of potato spirits, however, gave an impetus to the distillation from the exempted sources which progressively reached such dimensions that the price control of the Alcohol Administration became illusory. These conditions led to a revision of the constitutional basis of the law in 1930, and the corresponding "Alcohol Law" of June 21, 1932.

On the basis of the above constitutional amendment and law, as well as the Federal Council decree of December 23, 1938 and the partial revision of the Alcohol Act of October 25, 1949 which became effective March 1, 1950, the present status of federal control through the Alcohol Administration may be briefly described as follows.

The production of distilled spirits is exclusively the right of the federal authority, but the exercise of this right may be transferred to concessionaires (associations of small distillers and other private enterprises). Domestic distillers who distill exclusively for home consumption from produce of their own orchard or vineyards or from gathered wild products are exempted but must obtain a license which is free of charge. The same applies to persons who give, for their personal consumption their homegrown, or gathered wild materials for distillation to commercial distilleries. The tax free quantity distilled for home use is not limited, except for those domestic distillers who at the same time are publicans, or otherwise engaged in the spirit trade.

The federal government regulates the delivery, rectification, taxation and importation of ditilled spirits, the sale by the Alcohol Administration and the utilization of raw products for purposes other than distillation. Such utilization may be for fodder purposes, or the production of unfermented grape juice and other fruit juices, with government subsidy. Other federal tasks in this field are the fostering of fruits for alimentation ("table fruits"), and the decrease of the number of private stills through purchase. The number of private stills which in 1930 amounted to 38,934 has been reduced by approximately one third. The Alcohol Act of 1932 brought about a second sharp decrease in distilled spirit consumption.

The Federal Alcohol Administration in its endeavour to bring about the desired effects of the law has undertaken many constructive measures, among which may be counted an educational campaign on the utilization of certain raw materials for purposes other than distillation.

The Alcohol Administration expends roughly $3,500,000 for the utilization of potatoes and fruits and for a change in the fruit culture of the country.

Some comments have been voiced to the effect that the unfermented use of grape has been fostered mainly through consideration of viticultural policy but not through consideration of national health. Such statements are not quite to the point. No doubt the government had the interest of the viticulturist in mind, but the fact that they aided him to utilize his surplus grapes for unfermented juices, rather than for brandy, shows that they were also aiming at a reduction of the alcohol consumption.

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VII. BRIEF DESCRIPTIONS OF OTHER ALCOHOLISM PROGRAMS

The inclusion of some countries under the above heading does not necessarily imply that they do not have highly developed alcoholism programs. Thus Finland is among the countries which have an extensive and intensive program which, however, in many aspects overlaps with the Swedish and Norwegian activities and a full description would result in too much repetition.

On the other hand, some countries have limited programs which show, however, certain features not covered by other countries, and these original features merit discussion, e.g., the Netherlands.

For some countries, as for instance the Communist regimes, the information available is rather sketchy. And the programs of still other countries exist on paper rather than in practice. Lastly, there are in Australia, New Zealand and the Union of South Africa, programs which have been started too recently to warrant any lengthy discussion.

UNITED KINGDOM

Care of Alcoholics

England passed an Inebriate Act as far back as 1878, to provide special institutions for "inebriates". There is some recognition inherent in that Act that inebriety has some effects which distinguishes it from other misdemeanours. These special institutions were used very little and the Inebriate Act was permitted to become obsolescent.

It is difficult to decide whether or not one may legitimately speak of public care of alcoholics in the U.K. today. There is no compulsory treatment of such patients. There is no definite government program on alcoholism, except the regulation of sales of alcoholic beverages in pubs, restaurants, hotels and clubs.

At present, theoretically at least, the National Health Act should offer every "alcoholic" in England the opportunity to receive free treatment for his condition. Actually, an alcoholic who applies to a physician for the treatment of any of the consequences of his "alcoholism" will receive such treatment, but if his request relates to the treatment of his habit, the matter will not be regarded as a medical one except by a few highly specialized psychiatrists and internists. This attitude relates to the concept that the habit is merely "bad behavior" and the remedy is to behave better.

In view of this situation, some physicians have urged special legislation for the creation of facilities for the medical treatment and rehabilitation of "alcoholics". Such proposals, however, are met with the argument that the National Health Act makes such specific legislation unnecessary. Theoretically, of course, this argument is correct. Actually, the existence of a National Health Act does not necessarily exclude legislation on treatment facilities for alcoholics. An example of such twofold legislation is seen in the case of Chile (see farther below).

There are, however, in England and Scotland, some greatly limited special services for alcoholics--limited in the sense that they are prepared to deal with very small numbers of alcoholics. While the hospitals in which these services are provided are in a sense public institutions, their alcoholism services depend largely upon the special interest of one or two staff members in the field. Particularly notable among these hospitals are the Warlingham Park Hospital in Surrey, the Maudsley Hospital in London, St. Bernard's Hospital (London) with in-patient facilities for alcoholic women and St. Marylebone Hospital with an out-patient service for alcoholics.

At Warlingham Park there is accommodation for 18 alcoholic patients (12 males and six females) and there is a long waiting-list. This hospital also operates two out-patient clinics for alcoholics at Craydon General Hospital and Mayday Hospital. At Warlingham Hospital, alcoholics are thoroughly indoctrinated into the understanding of the process of alcoholism. Lectures are given and group therapy is practiced rather intensively. There is also individual therapy. Largely, the Warlingham alcoholic group is structured on the A.A. pattern, and on discharge, patients are expected to join an A.A. group. The St. Bernard unit for alcoholic women is operated on the same principle as at Warlingham Park. The alcoholism services at these two hospitals are largely due to the unceasing efforts of Dr. M. Glatt[1]. The publicity attached to the Warlingham activities as well as to Alcoholics Anonymous, has brought the illness concept of alcoholism somewhat nearer to the English public.

The Maudsley Hospital in London is a post-graduate teaching hospital for the treatment of all types of mental illnesses including alcoholism and drug addiction. While psychotherapy of alcoholics receives much attention, a large variety of drug therapies are used, particularly in view of clinical research which is one of the important features of that teaching hospital. There are in-patient as well as out-patient services.

There are other public or quasi-public hospitals in England which have some interest in alcoholism, but they have only small facilities for

alcoholic patients. Among these are Guy's , St. Thomas and Middlesex Hospitals in London, Lady Chichester Hospital in Sussex and Stone House Hospital in Kent. The Addenbroke Hospital in Cambridge is noteworthy for its out-patient clinic specially devised for alcoholics. The service used to be limited to every alternate Wednesday, but lately this service has been transferred into a separate, daily operating unit.

In 1961 increased activity in the field of care of alcoholics was seen in England. Alcoholism units were established in public hospitals located in Liverpool; Basingstoke, Hampshire; Epsom, Surrey; Birmingham; Gloucester and Oxford. These new units, too, are small projects and they are only indirectly under the National Health Service.

Some private facilities may be mentioned. Wyke House in Isle Worth, Middlesex, is one of the last private mental hospitals. Its bed capacity is small, a little over 30 beds. Approximately one-third of the patients are alcoholics. This hospital has an out-patient service also. Although the head of Wyke House is a psychiatrist, his conviction is that alcoholism is of physio-pathological origin and consequently, this hospital places much more emphasis on drug treatment than on psychotherapy. The predominant procedure at Wyke House is the aversion treatment by means of apomorphine. Nevertheless, Temposil and Antabuse are used too.

Interestingly enough, there is a service for alcoholics operated by a total abstinence group known as the "Temperance Society". They operate two out-patient clinics, one in London and the other one in Southworth. Not more than 60 to 70 patients are treated annually in these clinics (some of them repeatedly). The administrator of the Society is interested in the propagation of the idea that alcoholism is an illness. In this, his Society differs from other temperance movements in the U.K. The clinics of the Society are not known to the present reviewer who has learned about them through Popham (1960).[4]

In Scotland, the Crichton Royal Hospital of research fame - an institution under the National Health Service - operates a unit for the treatment of alcoholics. In accordance with the research program of this hospital, a variety of treatment methods are used, but psychotherapy plays a role in all treatment schemes.

Legal Controls of Sales

Before the First World War, the problem of drunkeness among the lower economic classes of the U.K. was a very serious one. In the First World War, many restrictive measures were introduced, mainly the "permitted hours" for pubs which the hours of sale reduced from 17 hours

a day to 5 1/2 hours on week days. The pubs were closed at times when people went to their places of work and when they returned from them to their places of residence. This measure, of course, eliminated the vexatious problem of "pub crawling". No doubt, the introduction of "permitted hours" has contributed to the drastic decrease of drunkeness in the U.K. between 1914 and the present. In the period between 1914 and the middle 1950's, there was a decrease of nearly 75 per cent in the number of arrests for drunkeness. There has been in the past six or seven years some increase in drunkenness, but not to an alarming degree. The principle of "permitted hours" has been kept in effect although after World War II, restrictions were eased to some extent, as for instance in the London area "permitted hours" were extended to nine hours with a break of two hours after midday. The great reduction of the problem of drunkenness cannot be attributed exclusively to these measures. A decrease in the consumption of alcoholic beverages and a decrease in drunkennes (but not necessarily in alcohol addiction) has been seen in most European countries, and may be ascribed to higher standards of living in general, and to many activities which "compete" with drinking.

In 1960 a new Licensing Bill was introduced in the U.K. This Bill provides a slight extension of "permitted hours" across the whole country. It eases the stipulations for drink licenses for restaurants, removes the restrictions on off-licence sales on week days and eliminates some other restrictions such as the ban on hotel residents to treat their visitors after permitted hours.

The Bill contains some provisions which may be regarded as "almost a social revolution". First, there will be a new sort of licence to permit the sale of drinks to residents in boarding houses and private hotels. Broadly speaking, this and the new restaurant licence, or a combination of the two, will be obtainable as a right, subject only to the fulfilment of certain conditions about the character of the applicant and of his establishment, such as the extent to which the premises "are patronized by young persons".

The Bill also pays attention to Sunday opening of pubs in Wales. A poll on Sunday opening will be able to be held in each country or county borough if a requisition is signed by not less than 500 local government electors. All such requisitions must be made within two months of the act's coming into force; polling will take place everywhere on the same day; and the decision will not be challengeable for a period of seven years. Another provision is the allowing of a fifteen minute "drinking up" period after the end of permitted hours. The increase in fines for serving drinks outside permitted hours (30 to 100 pounds) and for serving them to those under 18 (one to 25 pounds) will be generally considered reasonable.

The Bill proposes registration of all clubs. It had been widely supposed that a basic distinction would be made between members' clubs and proprietary clubs, and that only the latter would require registration. The Government has evidently concluded that the ease with which proprietary clubs could turn themselves into membership clubs has made this approach unworkable. All clubs with drinking licences will now have to be registered annually; and the police, the local authority or local residents will be able to object to such registration - if they can show that the club is being habitually used for unlawful purpose, or for indecent displays, or as a resort for criminals or prostitutes. A provision lays down that in every case forty-eight hours must elapse between a person's becoming a member and his admission to the privileges of membership. The rights of bona fide clubs are protected by the granting of an appeal to Quarter Sessions against any refusal of registration. (For description and comments on this Bill see various September and October issues [1960] of the OBSERVER).

In summary it may be said that outside of a highly developed system of sales controls the United Kingdom has no alcoholism program.

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FRANCE

As the country with the largest alcoholism problem, France is of particular interest. There is a wrong impression outside of France that the alcoholism of that country grew to its extraordinary proportion quite suddenly in the early 1950's. The problem was as vast, or even greater before 1939 than it was in 1950. As a matter of fact, hundreds of public statements were made by Frenchmen to the effect that the military disaster of that nation was the outcome of the "alcoholization" of the population whose physical and moral stamina was undermined by drink. During the Second World War, there was a relative scarcity of alcoholic beverages.

But more importantly, the Vichy government had introduced such stringent controls - of production and sales - that the incidence of excessive drinking and alcoholism was drastically reduced. This was evidenced by extremely sharp drops in hospitalization for delirium tremens, admissions for alcoholic psychoses and death from cirrhosis of the liver. In 1945, the measures of the war years were dropped, and by 1950 the incidence of alcoholism had increased nearly to pre-war level. It was this contrast between conditions in the war years and the post-war era which brought the magnitute of the problem first to the awareness of some research workers and a group of physicians; next to the awareness pf public officials, and lastly to a certain degree to the French people in general. The dramatic attack on these conditions by Mr. Mendes-France came as a shock to the general public in other European countries and in the Americas, which had long believed that Frenchmen were practically immune to alcoholism. Except for a few measures, Mr. Mendes-France failed to put his proposed controls across, but later cabinets could not ignore the problem and could not drop the idea of certain controls.

Care of Alcoholics

The first ambulatory clinics for alcoholics were established in Paris in 1946. These were and are operated by the municipal government. Outside of Paris, few municipalities had established such clinics before 1951. Under the impact of the World Health Organization's European Seminars on alcoholism, the activities for the care of alcoholics increased in France. The Public Health Office of the Department de la Seine organized a consultation service for alcoholics and some other Departments and Provinces of France followed the example. By decree of May 20, 1955, the National Government grants some subsidies to the Dispensaries of Mental Hygiene. These facilities for alcoholics are run practically entirely by social workers and of these a few have high qualifications, but the majority have little preparation for this special field. It is, nevertheless, mainly due to social workers if the idea of the disease nature of alcoholism is slowly gaining some recognition in France. Limited as the services of the "dispensaries" are, they have achieved some results. It should be mentioned that many of the successful patients are induced to join a "Group of Recovered Alcoholics". Such groups are related either to the Protestant Croix Bleu, the Catholic Croix d'Ore or the movement known as La Vie Libre. The spirit of these groups is much nearer to the old line American Temperance Societies than to Alcoholics Anonymous.

National legislation on the treatment of alcoholics -- that is to say on a limited segment of the alcoholic population -- was achieved by an Act of April 15, 1954, on the compulsory commitment of "dangerous alcoholics". According to this Act, alcoholics who are recognized as

dangerous to others and to themselves must be brought to the notice of the health authorities. The authorities enquire into the condition of the alcoholic in question and submit him to a medical examination. The health agency advises the "dangerous alcoholic" to change his ways and refers him to a "dispensary" or some other institution. Whenever it is evident that the dangerous alcoholic in question will not succeed if left in liberty, a medical commission can demand his appearance before the Department of the Attorney General, and a tribunal can order his internment. As no special facilities have been established for this purpose, the burden of care falls for the time being on the mental hospitals which, of course, are not in the position to admit more than a small proportion of these persons.

A National legislation for the care of other than "dangerous" alcoholics does not exist in France and there is no attempt to bring alcoholics to treatment at an early stage of their condition. Such activities are however, fostered privately by the "Groupment Médical Contre l'Alcoolisme" and the lay group known as "Comité National de Défense Contre l'Alcoolisme.

Preventive Education

The main activity of the National Government in the field of alcoholism is centred on preventive education. This interest is motivated not only by the basic idea of "an ounce of prevention.." but by a not quite admitted conviction that not much can be achieved with alcoholics. Preventive education is entrusted to the "Haut Comité d'Etude et Information sur l'Alcoolisme". This agency is under the jurisdiction of the Prime Minister's Office. The creation of this committee is largely due to the insistence of the Economic Council (of France) and particularly to the zeal of Dr. Etienne May. It was Mr. Mendes-France who inaugurated this agency on February 9, 1955.

The objectives of the committee are to assemble the largest possible body of facts on alcoholism; to disseminate information on this subject among the population; to make recommendations to the government on the means of reduction of the problem, and to promote collaboration of other organizations in this work.

The main objects of the propaganda of the committee are expressed in the following four slogans:

"No habitual use of apéritifs, nor of distilled spirits".

"Never more than one litre of wine in the course of a day".

"In general, no alcoholic beverages outside of meals".

"No alcoholic beverages for children".

That the aim of moderation is not more than "1 litre of wine in a day", reveals the excessive habits with which preventive education must cope in France.

After a poor start which utilized posters and pamphlets, which Canadian and American Temperance Societies would have regarded as outdated some 25 years ago, the committee has come to an effective means of communication about drinking in their country, and the four slogans have undoubtedly made some impression on the French population. At least one observer, De Boe (1961)[3] has expressed misgivings about the effect of these posters on alcoholics. The ideas on moderation as expressed in the Committee's posters may be an encouragement for alcoholics to continue their drinking. For specimens of modern posters of the Comitè see that agency's report of 1958. More recently the "Comitè" has developed one-minute films which are widely shown.

The vested interests have viewed the educational campaign with a jaundiced eye. The Executive Vice-President of the Haut Comitè, Mr. A. Barjot[4], made no bones about stating publicly that the Ministry of Finance has opposed the campaign for several years and only recently, under the impact of convincing facts, has given up its opposition.

Research

There is no French national institute devoted specifically to research on alcoholism, nor is it necessary to create one as systematic research on this subject is well taken care of by the Institut National d'Hygiène. In particular Dr. L. Dèrobert and his associates, and a team headed by Messrs. S. Ledermann and H. Bastide at the Institut Nationale d'Etude Demographique, have produced outstanding research. (The studies of the Demographic Institute sparked the interest of various public authorities in the problems of alcohol in France.) Furthermore, there is research on these matters in various French Universities. The French scientific literature has been and continues to be intensive and meritorious.

Much of the research carried out at universities and hospitals is subsidized by the Haut Comitè which is not an operating research agency but rather a documentation centre and a source of educational materials. The "Comitè" published in December, 1958, a report on the research projects it has subsidized. The projects cover a wide range, including biochemistry, physiology, economics and political sciences. Quite a number of these research projects are devoted to wine and its effects with the conclusion that in general wine is a "hygienic beverage".

In the past three years the "Comitè" has not published any more reports of the research it has sponsored.

Control of Production and Sales

In the past, with the exception of the period 1940-1945, there has been little effort to exercise any control over sales. As to production, there were largely oenological regulations to safeguard the purity of wine. There was, of course, the ban on absinthe which was blamed for all evils to the exoneration of wine. Licencing of on and off premises sales is still very lax.

The great problem with which the government has to cope at present is the tax-free distilling privilege of vineyard owners and orchard owners. Such distillers numbered close to 3,500,000 in 1954, but now the number has dropped to about 2,200,000. This distilling privilege has always been regarded as practically a sacred prerogative of vintners and orchard owners, particularly apple growers, and it is a touchy subject to tackle. Mr. Mendes-France tackled it head-on and failed. President de Gaulle seems to have a feasible but somewhat slow solution for this particular problem. His intention is not to abolish the privilege but to let it die out through not renewing the licence after the deaths of the present owners.

The Government Program on Alcoholism

The alcoholism program of the French government is constituted by three items.

(1) The compulsory internment of "dangerous alcoholics", but for this appropriate facilities are lacking.

(2) Preventive education.

(3) Partial control of distilled spirit production through the medium of not renewing the privilege after the death of the present licencees.

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THE NETHERLANDS

Care of Alcoholics

The system applied in the Netherlands may appear to the observer from a foreign country as a very loose one, or even a lack of system. On closer acquaintance however, it will be found that there is a great measure of order and integration in these activities. The first impression of a lack of system arises from the fact that the care of alcoholics is in the hands of Consultation Bureaux which are founded and operated by a variety of denominational and other philanthropic organizations; the "founding fathers" may represent a variety of outlooks on alcoholism and alcoholics. Actually, the various consultation bureaux have in a sense their own individualities, but they submit to a wholesome measure of common guiding principles. In the course of their historical development which dates back to 1912, the common guiding principles have evolved in a way which amounts to an admirable system, although some of the individual differences may be subject to criticism.

The observation of minimum standards became necessary through the common source of finances, namely the subsidies by government which cover the entire budgets of the bureaux. Until 1960 the National Government, through its Ministry of Social Affairs and Health, provided 60 per cent of the budget and the remaining 40 per cent was covered by Provincial and Municipal Governments. Since 1961, the entire budget is supplied by the National Government. Thus government assumes the full financial responsibility for the care of alcoholics. It is only natural that the public authorities which supply the funds, must have a certain guaranty that their investments are justified. The guaranty is constituted by the standards which are set by a Federation of Consultation Bureaux for the Care of Alcoholics. The Ministry of Social Affairs and Health, some other Ministries, University faculties and the Temperance Societies are represented in the Federation. A further tie in the order of management is the existence of a section on all matters connected with alcoholism, including the matter of licenced premises. This section is headed by a Chief Inspector who is aided by an adequate staff. The manifold duties

of the Chief Inspector include "the observation of drinking habits and their concomitant phenomena", in order to enable him to submit suggestions for the elimination of certain abuses. Thus, there exists a coordination of prevention and treatment in Holland.

The Consultation Bureaux have developed in the course of years into full-fledged out-patient clinics, and since 1961 some of the Bureaux have added an in-patient service, but have retained their original designation. The standards evolved in the Federation describe a consultation bureau as an institution with manifold functions which involve all aspects of medical-social work, mental hygiene, matters of probation, the treatment of psychopaths, child protection and many other forms of social work. The bureaux must carry out group therapy, individual psychotherapy and, to a certain extent, chemo-therapy. All these functions require of course, that while the main burden of the treatment activities devolves upon trained social workers, there must be on staff also consulting psychiatrists and consulting physicians and fully qualified nurses. The bureaux, or more properly, clinics in the large cities such as Amsterdam, have of course, more psychiatric and medical and psychological consultants than the clinics in small communities. Furthermore, in the larger cities, the clinics may be affiliated with a municipal hospital and thus have access to special diagnostic services and, in case of severe acute intoxication or other organic complications, they may refer the patient to the hospital for a few days of bed care.

The variety of duties requires that the staff have besides their basic training, a great familiarity with the specialty of dealing with alcoholics. As the number of bureaux, i.e., clinics, has grown to 17, there is a continuous demand for qualified staff members. For this purpose, the Federation organizes from time to time, special training courses which consist of 113 hours of lectures on such subjects as the physiopathology of alcohol, psychology and therapy of alcoholics, social psychiatry, legal aspects, case-study and so forth.

At least half of the referrals come from the courts and are cases of probation for minor misdemeanours connected with alcoholism or other drinking problems. In a sense this constitutes a form of greatly limited compulsory treatment of alcoholics. There is, in addition, an enabling act of 1923 which provides that alcoholics who cannot look after their own interests properly, cannot provide for their families, endanger their own lives and the lives of others, may be declared minors and placed under tutelage, at their own request or at the request of the wife (husband), other relatives or the prosecuting authorities. A guardian is appointed (for one year) who may propose compulsory treatment. As such patients require intramural treatment, they are referred not to the clinics but to special institutions designated by the Ministers of Social Affairs and Public Health and of Justice.

There are also a number of sanatoria for the in-patient care of alcoholics other than those under compulsory care. The standards for these sanatoria is being developed progressively.

Education

No special effort has been made by the government relative to education of the public at large on the effects of alcohol and alcoholism. Such activities are carried out by the temperance movement. Among other things, the temperance societies publish a monthly magazine exclusively devoted to "alcohol-free driving".

The presence of 17 clinics (and a number of special sanatoria) in such a small and densely populated country as the Netherlands, of course, brings home to the population the idea of the treatability of alcoholism. Everybody knows about these clinics, if by no other means, through their proximity. Thus the treatability of alcoholism does not require a special propaganda effort.

Research

The standards for clinics suggested by the Federation, include provisions for comparable records on all aspects of the clinics' patients, and on their treatment, in order to enable clinical workers to carry out some research through joint efforts. The extent of such research has been rather limited in the Netherlands. In the second half of 1961 the National Government provided a moderate sum for research. It may be mentioned that the Amsterdam Clinic has tens of thousands of case records dating as far back as 1912. One of the first research projects will be an analysis of these records.

Sales Controls

Legal control of the sale of alcoholic beverages is based entirely on a licence system. There are five kinds of licences: (1) full licence for the sale of all types of alcoholic beverages to be consumed on or off the premises, (2) "tap" licence referring to all types of beverages but limited to on-premises consumption, (3) retail licenses for all types of beverages but exclusively for off-premises consumption, (4) hotel licences, and, (5) club licences.

All these licenses have a large number of stipulations attached to them, such as the size, ventilation and lighting of the locales, types of persons not permitted on premises, and other stipulations usually encountered in any well regulated licencing system. It is noteworthy that the age at which persons may be served drinks or sold alcoholic beverages by the bottle is set at 16 years.

Another feature of control is the limitation of the number of sales outlets according to the population size of the community in which they are located. Larger cities, e.g., those of 50,000 or more may have one outlet for each 500 inhabitants, while in a town of 10,000 inhabitants, there may be one outlet for each 250 inhabitants.

It may be mentioned that for some years there has been a controversy in the Netherlands about the value of abolishing the off-premises sales and limiting sales to public drinking places. The idea behind this is to keep liquor out of the home. This idea is propagated by the temperance movement and has little prospect, if any, for enactment.

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BELGIUM

Care of Alcoholics

One cannot justifiably speak about a government program on alcoholism in Belgium. There is no legislation on the treatment of alcoholics. Belgium has a National Committee Against Alcoholism that originated in the Temperance Movement. As this committee is now entirely government supported, it has a semi-official status. This agency has three main program points: (a) the ambulatory treatment of alcoholics in consultation centres, (b) youth education on the effects of alcohol, and (c) a campaign on alcohol and traffic accidents. As the committee has been greatly influenced by the seminars and publications of the World Health Organization, it propagates the idea that alcoholism is an illness. It had a significant role in bringing about the creation of an Alcoholics Anonymous group in Belgium. The efforts of the committee in the field of treatment of alcoholics is valiant, but on account of budgetary limitations, activities are restricted to small pilot ventures. In educational ventures the committee has been much more successful. Its pamphlets and posters are very effective; the materials are well chosen and the presentation avoids the elements of fear and rather appeals to the element of prudence.

Research

In 1961 the creation of a Centre for Research on Alcoholism at Ghent University was announced. This new institute has been formed by an association of research workers, notably the distinguished biochemist Dr. Henriette Casier and the psychiatrist Dr. Verenne. The "Centre" is a private undertaking but enjoys the moral support of Ghent University as well as the laboratory facilities of that institution. Projects are contemplated in the fields of physiology, pharmacology, biochemistry, psychiatry and the social sciences.

Sales Controls

There is only one feature in the Belgium control law which is of interest and which has remarkable consequences. That is the control of the sale of distilled spirits including apèritifs. Restrictions on the sale of that type of alcoholic beverage date back to the Vandervelde law of August 29, 1919. According to that Act, distilled spirits and apèritifs cannot be sold by the glass, nor by the bottle, in any drinking place, nor can they be sold by persons who sell fermented beverages. Furthermore, it cannot be sold in a quantity of less than two litres. In view of the high licence fees for the sale of distilled spirits and the high tax on them, the purchase of a two litre bottle is out of the range that the majority of the population could afford. One year after the passage of the Vandervelde law the apparent consumption of distilled spirits dropped 66 per cent. A few years after that Act was passed, admissions for alcoholic psychoses and arrests for drunkenness decreased by 50 per cent. The remarkable fact is that in spite of heavy pressures, the governments of Belgium were able to keep this law in force up to the present. One exception has been made in connection with the tourist flow to the Brussels World Fair, and that is that bona fide tourists might be served distilled spirits by the glass, in a special "club room" of the largest hotels. This tourist privilege was perhaps occasionally abused by residents of Belgium, but such abuse would be statistically insignificant.

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FINLAND

The public care of alcoholics and the sales and production controls of Finland largely follow the Swedish pattern, but there are certain features which merit mention. In the matter of organized government research on alcoholism, Finland did not follow Sweden and Norway, but rather constituted an example to those latter countries.

Public Care of Alcoholics and Other Excessive Drinkers

Three separate laws cover care of excessive drinkers and alcoholics. The first of these (1936) deals with adolescents below the age of 18 years. The administration of this law falls within the jurisdiction of Child Welfare Boards. Actually, this law has been applied only to those adolescents below 18 years of age who have been arrested on account of intoxication, although the law provides that a mere attestation of intoxication in such a person should suffice for the Child Welfare Board to take action. Furthermore, in these instances until recently only warning and instruction have been applied, but as the incidence of intoxication among such young persons has increased, recourse has been taken to more severe measures.

For persons in the age range of 18 years to 21 years, arrests for drunkenness come under the Temperance Welfare Law. Loss of freedom or institutional care is not involved in these instances, but guidance and follow-up inspection may be exacted for the duration of one year. This law was enacted in 1947.

The law concerning true alcoholics, enacted in 1937, was originally administered directly by the Community Social Welfare Boards, but because of the many duties of those boards (poor relief, assistance to the war-disabled, maternity relief, etc.), the care of alcoholics has been largely placed into the hands of Community Temperance Boards. While even in instances of true alcoholism out-patient treatment is favoured, there are provisions for the compulsory treatment of alcoholics in special institutions or in more general public institutions which admit alcoholics.

There are at present five out-patient clinics for alcoholics known as A-Klinika(s). Besides these there are at least 10 facilities for the institutional care of alcoholics. Some of these facilities are operated by denominational societies. The institutions have a total of approximately 500 beds.

The treatment consists largely of group psychotherapy, but there is also administration of Antabuse and Temposil. The burden of psychotherapy is carried largely by social workers without much guidance

by psychiatrists. Of course there are not sufficient psychiatrists to take care of alcoholics and, in principle, the leadership of social workers in matters of group therapy is quite acceptable, provided that these workers are properly trained and qualified for such work. These desiderata do not seem to be sufficiently fulfilled in Finland. Generally the Finnish social workers are too rigid and authoritarian to carry out these functions, a fact that is recognized and admitted by expert students of alcoholism in that country.

Mention must be made of the A.A. movement in Finland. The reported membership number is perhaps greatly exaggerated (as in many other countries), but it is a rather effective group and in its character is very near to the North American fellowship of Alcoholics Anonymous. The mode of expression and the questions asked in a meeting give the impression that one is in an American group of A.A.'s talking with a foreign accent. The Finnish A.A. is becoming more and more an important means for the recovery of alcoholics.

Alcohol Education

The instruction of the public at large regarding the effects of alcohol is almost entirely in the hands of the temperance societies, and this is the weakest point in the Finnish alcoholism program.

Research

The most noteworthy element of the Finnish alcoholism program is an excellently devised research activity which is carried out in the Finnish Foundation for Alcohol Studies. That Foundation is financed by the Finnish Alcohol Monopoly Board (Oy Alkoholinike A.), but without any strings attached to it.

The Finnish Foundation, as a government research institute on alcoholism, antedates its Swedish counterpart by several years. In the beginning the Foundation mainly fostered projects by research workers outside of the research institute, but has become progressively more and more of an operating research agency, but by no means to the exclusion of research grants to independent research workers.

The Foundation is engaged in research in the social sciences and in biological experiments. The well conceived research program has been of great value in application to administrative matters and questions of alcohol policy, but the Foundation has not neglected research of a more basic nature, and much attention has been paid to methodology. Of particular interest was the project of introducing the sale of light alcoholic beverages into a "no sales" territory and evaluating the effects of

this experiment on various aspects of social behaviour. Considerable attention has also been given to the technique of follow-up studies of discharged alcoholic patients. The sociologists of the Foundation have taken great interest in drinking customs and in the drinking behaviours of small groups. At present the Foundation is engaged in a research project which has been greatly neglected in all countries, namely an investigation of drinking patterns including alcoholism, in identical twins and fraternal twins. The sample consists of 200 pairs of Monozygotic twins and approximately 700 fraternal twins and pairs consisting of one twin whose twin brother has died and the remaining twin is paired with a non-twin brother. The subjects range at present within the ages of 30 to 40 years, and for that given age range the subjects represent the Finnish "Universe" rather than a sample of the twin population. The only report available at the time of this writing is on "The Determination of Zygosity" which turns out to be much more complex than one would imagine. The project is a co-operative one between sociologists, psychiatrists, psychologists and physiologists. (See Appendix page 88).

The biological section of the Foundation has contributed to the knowledge of alcoholism and the differential psychological effects of various types of alcoholic beverages, etc. "Conflict experiments" have been carried out also.

The Alcohol Monopoly

Efficient as the Finnish alcohol monopoly system is, after the description of such systems in Sweden and Norway there does not remain much to say about the Finnish one. The Finnish people lay greater stress on the production of distilled spirits by the monopoly company than does Sweden, but they do not exclude production licences to private undertakings as long as the products are sold exclusively to the monopoly. There are no sales in the rural areas, and the urban communities exercise the privilege of local option.

The Finns did not follow the Swedes in abandoning the purchase books, but as far as this reviewer is aware, they have given up the most unsatisfactory feature of the "buyer surveillance".

Sources:

1) The Finnish Foundation for Alcohol Studies, Report on Activities, 1954-1958, Helsinki, 1959.

2) Issues of the journal, Alkoholpolitik.

3) Popham, R. Miscellaneous Notes of Interest in the Alcohol Field: European Countries, 1958-1959, Toronto, 1960.

4) Sammalisto, L. The Determination of Zygosity. Helsinki, 1961 (mimeographed).

5) Oral and Written information by Drs. S. Sariola, Kettil Bruun and O. Forsander.

GERMANY, AUSTRIA, ITALY, SPAIN AND PORTUGAL

Interest in the public care of alcoholics has greatly diminished in Germany and Austria. Both of these countries incorporate in their laws the disease concept of alcoholism largely for the purpose of health insurance. Furthermore, these countries have laws on the compulsory treatment of certain types of alcoholics, but these laws are on the books rather than in practice. Austria has in principle an enabling law to place under tutelage alcoholics who cannot take care of themselves and their families. This provision of the law is rarely invoked. In Germany the rehabilitation of alcoholics rests in the hands of a government-subsidized group of voluntary welfare workers who are all total abstainers. The subsidy and other sources of income are much too small to deal with more than a very small sample of the alcoholic population.

An Italian National Institute on Nutrition has long been active in research on the relation of wine consumption to liver damage and to nutrition in general. The workmanship of their investigations is good, but the interpretation is biased in favour of the national product.

From the angle of sales controls neither of these countries have anything of particular interest to offer. Their licence laws are verbose but largely they follow a cut and dried pattern. As wine producing countries they have, of course, laws for the protection of quality of the wine.

Italy and Portugal are hardly aware of having alcohol problems and do not feel any need for alcoholism programs. According to an item in The New York Times, Spain opened a clinic for alcoholics in Madrid, in April 1961. Italy differentiates in its criminal law between "chronic alcoholics" and "habitual drunkards". The latter are liable to penal measures, but the former may be compelled to undergo treatment. What treatment means in this instance remains unknown nor is there anything known of the application of this provision in practice.

While the Italian government officially disavows the existence of an alcoholism problem in their country, they do have certain restrictions on sales, in particular through the medium of limiting sales outlets to one for each 400 of the population and banning "mobile wine canteens" from military areas, hospitals and most public buildings.

In Spain, there has been some recognition lately of an alcoholism problem and there have been some proposals that the public health service should take a hand in the treatment of alcoholics.

In Portugal a few psychiatrists have recognized the problem and have opened out-patient departments for alcoholics in two or three mental hospitals. But even the Ministry of the Interior, to which the public health service is attached, does not seem to know about these out-patient clinics which depend entirely upon the special interests of some medical men who do not give any publicity to this service.

The oenological laws of Italy, Spain and Portugal constitute veritable mazes through their numerous and elaborate amendments.

Sources:

1) Entirely based on oral and written information by experts of the countries in question.

ALCOHOLISM PROGRAMS IN THE COMMUNIST COUNTRIES

With the exception of Yugoslavia, this reviewer has no first hand knowledge of alcoholism in the communist countries.

Russia

The alcoholism literature of Russia has been swelling considerably and the interest in these matters would indicate that the problem of alcoholism is fairly large in that country. In 1959 a symposium on alcoholism was published in Moscow under the title "Alcoholism". This book is a collection of 58 papers of which seven come under the heading of organization of the campaign against alcoholism; 15 papers deal with the clinical aspects of chronic alcoholism and the alcoholic psychoses; 11 papers are devoted to the pathogenesis of chronic alcoholism and are straight research papers; and 25 papers pertain to treatment. This large volume of 448 pages has been insufficiently reviewed in the English language. Efron (1960)[2], in her excellent discussion of the Soviet approach to alcoholism hardly touches this book on account of space limitations. As far as one can judge by abstracts, the Russian alcoholism literature - not counting the ranting propaganda papers - would merit careful study.

Apart from the pillorying of alcoholics and the numerically and qualitatively deficient sobering-up stations, the treatment in neuropsychiatric dispensaries seems very much the same approach as is practiced in the North American Continent, Efron points out.

The official communist standpoint is that alcoholism is an outgrowth of all the evils of capitalism, but now that more than 40 years of Soviet regime have not stamped out the disorder, the disease concept seems to come in quite handy. The treatment of alcoholics through medicopsychiatric means, such as hypnosis, Pavlovian conditioned reflex and disulfiram administration is, in the Soviet Union a matter of public care. Since 1926, there has been compulsory treatment of alcoholics "who constitute a social danger". According to the 1956 edition of the Russian Medical Encyclopedia, quoted by Efron, this "instruction" has not been applied in practice.

As to public education on alcoholism, there exists a strong propaganda in the Russian press. This reviewer has received some clippings with English translations in which the tone of the Russian anti-alcoholism propaganda is very reminiscent of the old-line American Temperance literature, without, however, advocating abstinence.

Of production and sales control in the Soviet Republic practically nothing has been communicated to the outside world.

Czechoslovakia

In Czechoslovakia the public care of alcoholics seems to be handled by the Public Health Service on a good medical level. Dr. Jaroslav Skala (1957)[2] gives a good account of alcoholism and its treatment in that country. The present Czechoslovakia has inherited not only an alcohol problem but also some experience in the public care of alcoholics. In 1925, the first alcoholism clinic was organized in Prague, and between that year and 1945, another two clinics were established. In 1948 the first independent department for alcoholics was opened in Prague and since then 10 such departments have been created. In addition, between 1951 and 1955, 140 "alcoholism clinics" were established in Czechoslovakia. These clinics were the outcome of an extensive government Antabuse campaign which reached 3000 alcoholics but with no great success. Many of the clinics organized clubs which assist alcoholics and their families. Aside from public care, there exists in Czechoslovakia a quasi-voluntary organization for aid to alcoholics. The Red Cross is said to perform educational work in this field.

In the field of sales controls there are great restrictions on sales of alcoholic beverages to persons who are engaged in work where impairment could be dangerous to safety and life (physicians, chauffeurs, mechanics, etc.). No sales may be made to persons under the age of 18 years. In spite of strict laws, there is quite some clandestine production of the national strong drink, slivowitz.

Poland

Poland is the largest distilled spirit consuming country and has a correspondingly large alcoholism problem. All social strata are touched by alcoholism, but the problem is greatest in the labour class.

The law of 1956 provides that any person who, in a state of intoxication, behaves disorderly, may be taken to a "sobering-up" place and detained there until he returns to normal behavior. At the end of 1959 such "drying-up" places existed in 13 centres. While many of these agencies are rather deficient they have the advantage of detecting true alcoholics. The latter are taken to the "Anti-alcoholic Dispensaries" for treatment of their alcoholism. More than 600 physicians, psychologists and nurses are employed in these dispensaries. The creation and management of these agencies are in the hands of the "Polish National Social Committee Against Alcoholism" which is nominally a voluntary agency. This Committee is responsible for the Anti-Alcoholism Act of December 19, 1959.

The latter act embraces all aspects of treatment as well as of sales controls. This act provides that each Voivodship (County) should organize and operate in-patient facilities for the treatment of "habitual alcoholics". The organization and operation of out-patient clinics devolves upon the municipal district's People's Councils. Regulations for in-patient services should be issued by the Minister of Health in agreement with the Minister of Justice. "Habitual alcoholics" who are a threat to their families and neighbourhood should be subjected to compulsory treatment at in-patient and out-patient services.

Compulsory treatment in in-patient establishments must be submitted by a socio-medical commission to a District Court for proper hearing. The duration of compulsory treatment should not exceed two years.

The socio-medical commissions and rules for their procedure should be determined by the Minister of Health in agreement with the Ministers of Justice, Internal Affairs, Labour and Welfare.

As to sales controls, it is unlawful to sell alcoholic beverages on the premises of educational establishments and in establishments "serving directly the movement of means of transportation".

It is unlawful to sell beverages containing more than 4.5 per cent of alcohol in working establishments, workers' hostels, on premises established for sports and physical training, swimming pools and places of open-air entertainment and recreation, in the "precincts of army barracks and military camps", markets and places of public congregation and tourist shelters. It is unlawful to sell beverages of more than 18 per cent alcohol in cafes and confectioners' shops.

An important clause is that the "People's Council" may prohibit within the area of its competence the sale of any alcoholic beverage on Saturdays and other accepted pay-days.

Whether these stipulations will cut down the consumption of distilled spirits (mainly Vodka) can be determined only three to four years after the above act takes effect (1960).

Preventive education is carried out by the National Social Committee Against Alcoholism and by the Red Cross Society.

Yugoslavia

Yugoslavia, with a large wine belt and a great production of prune brandy always had a large alcoholism problem which until the middle of the nineteen-fifties was largely ignored. It was on the intervention by the armed forces that the government began to take interest in this matter, which then was assigned to the Red Cross Society. The latter society had no previous experience with the management of this problem and it is remarkable that after two or three years of fumbling they succeeded in engaging the interest of professional groups and to create with their help quite efficient treatment centres for alcoholics; 10 in Serbia, three in Croatia, one in Slovenia and one in Macedonia. In Croatia there are, in addition, some out-patient clinics organized and operated by the Public Health Services. There is no compulsory treatment of alcoholics in Yugoslavia save for those with psychoses. But for the latter, admission to treatment centres is based on free consent of the patient. The Red Cross has propagandized the idea of alcoholism as a treatable disease, and has also engaged in the education of the general public and particularly of young people on the effects of alcohol. In their educational efforts, they have followed rather out-dated principles.

The regulation of the sale of alcoholic beverages is rather loose and calls for radical reforms.

Roumania

In 1961, in Amsterdam, the reviewer had the opportunity to see films on "alcohol education" produced in Roumania, Czechoslovakia and Poland, respectively. All these films have an element in common, namely the ridiculing of the alcoholic. Whether such methods are helpful for the alcoholic may be doubted. That such an approach is definitely detrimental to the attitudes of the public in general may be safely stated, as these films greatly contribute to the old public image that the drunk (and this includes of course, the alcoholic) is a comic figure. This attitude is particularly marked in the Roumania film which is slapstick comedy at its worst.

Sources:

1) Efron, E. Social Problems 1; 307, 1960.

2) Skala, J. Alkoholismus. (with English Summary), Prague, 1959.

3) De Boe, A. Les Problemes de l'Alcool en Tchecoslovaquie, Brussels, 1961 (mimeographed).

4) De Boe, A. Les Problemes de l'Alcool en Pologne, Brussels, 1960 (Mimeographed).

5) Polish National Committee Against Alcoholism, The Anti-Alcoholism Act of 19th December, 1959, Warsaw, 1960 (mimeographed).

6) League of Red Cross Societies, The Red Cross in the Campaign Against Alcoholism, Geneva, 1959.

LATIN AMERICA

In every Central American and South American country there is at least a nominal agency for the treatment of alcoholics. In Guatemala, Brazil and Peru there are considerable beginnings, but not of any special interest to students of alcoholism on the North American Continent. The only exception in this respect is the Republic of Chile. In this latter country there have been intensive and increasing activities since 1950.

Chile

In Santiago, Chile, there are two out-patient clinics and one hospital for alcoholics which, in the quality of their medical and social work services, are comparable to treatment services on the North American Continent. Since 1957 two out-patient clinics have been opened in provinces near Santiago. The National Health Service of Chile intends to establish in all of its 22 Health Districts facilities for the treatment of alcoholics. For this purpose they have established training courses of three to four months in which, each year, one physician and one social worker or nurse from three health districts are trained in the Santiago clinics, where lecture courses of 12 to 15 hours are also held. The main emphasis is on clinical experience. The trainees are also instructed in alcohol education by professional health educators.

Of special interests is the formation of a Research Institute which is a joint enterprise of the University laboratories of Nutrition, Pharmacology, Genetics and the Department of Psychiatry. This institute is

carrying out meritorious research and is training research personnel. The institute has no special grants for this purpose, but each of the constituent departments provides funds out of its budget for projects on alcoholism.

The instruction of the broad public on matters of alcohol is not undertaken by the government, but is left in the hands of the rather small temperance movement and the Red Cross Society. This has not achieved any success.

Sales controls are rather lax as they are opposed by a powerful organization of vested interests. Any legislative control is practically limited to oenological measures.

Sources:

There are no publications, outside of research papers, and the above remarks are limited to the present writer's observations and continued correspondence with Drs. J. Mardones, J.T. Marconi and T. Matte-Blanco.

APPENDIX

FINISH TWIN STUDY

With the kind permission of Mr. Robert Popham (Assistant Director of Research of the Alcoholism and Drug Addiction Research Foundation of Ontario) his notes on the Finnish Twin Study are given here verbatim.

The general purpose is to shed light on the extent to which variation in drinking habits, in general, and in alcoholism, in particular, may be accounted for by variations in hereditary factors, and to what extent by variations in environmental factors.

Although a revival of an old line of investigation, there are many new questions. The approach is interdisciplinary and perhaps of special interest because of this.

Sample comprises all male twins, of which both brothers were still living, born in Finland during the years 1920 to 1929 (from parish registries). Nine hundred pairs have been located; co-operation was obtained from about 90 per cent. These twins are now between 30 and 40 years of age. Zygosity determinations were made primarily on the basis of blood tests, employing the main groups and types. Two hundred pairs have been definitely identified as monozygotic. The remainder are mostly fraternal with a small doubtful category which may be removed through further biological study.

Controls are sociological, not genetic, and comprise 150 pairs where one twin has died and the remaining twin has a non-twin brother. These provide a control of sorts on the effect of "being the same age" on the socio-psychological relations between twins.

Biological phase: Forsander interested in inherited food preferences and whether centred in metabolic functions. This phase is still in planning stage but it is intended to do comprehensive physical examinations and take medical histories. Of course, zygosity diagnosis also fell in this area.

Psychiatric phase: Again in the planning stage and will probably involve many different small studies. One such has begun: all pairs showing any sign of mental disturbance having been selected out for special study.

Psychological phase: A comprehensive personality inventory and a form of I.Q. test are to be administered. The results will probably be subjected to factor analysis to determine how far, in general,

identical twins are alike in personality characteristics, neuroticism, introversion-extraversion, etc. Also in cases where one is an alcoholic and the other is not, there arises the question as to which personality factors 'explain' the difference.

Sociological phase: An attempt will be made to construct an index of environmental similarity for use in many aspects of study. It will be based on the extent to which the members of each pair belong to the same groups, have the same friends, status, residence pattern, etc. It is also hoped to learn something of the effect of war on the development of alcoholism: half were in and half were not. They will also try to classify pairs according to "power relationship", i.e., whether one is dependent and submissive, the other a leader; extent of competition between them, of mutual dependence, extent of interest in same things, similarity in school results, success with girls and the like. It is hoped to relate such variables to the later development or non-development of deviant behavior, especially alcoholism.

Results to date: All members of the sample have been personally interviewed on the basis of a lengthy questionnaire designed chiefly to get sociological data and some medical data. The results are in process of being tabulated. One tentative finding may be mentioned, namely, that roughly the same prevalence of alcoholism occurs among identical as among fraternal twins (about 10 per cent), but the concordance is higher for identical (50 per cent) than for fraternal (30 per cent) twins in alcohol habits, generally. These results agree with those of Kaij, obtained in a Swedish study (Proc. First Internat. Congress Hum. Genetics, 1956).

Alcohol habits were scaled as follows:

(1) Abstainer

(2) Small amount on the last two drinking occasions

(3) Larger amount and one symptom of alcoholism

(4) Larger still and one symptom of alcoholism

(5) Very large consumption on the last two drinking occasions and both symptoms of alcoholism

(The 'symptoms' of alcoholism referred to were hangover drinking and blackouts, the two shown in a previous study to be the best discriminators between alcoholic clinic patients and normals).